

## CERTIFICATE OF DEATH

Reg. Dist. No.

01789

1802

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN lb <b>537 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Jackson</b> Last <b>Barkley</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-26-1900</b>
9. AGE (In years last birthday) <b>59 yrs.</b>		IF UNDER 1 YEAR Months <b>59</b> Days <b>10</b> Hours <b>1960</b>	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscaper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>	
11. BIRTHPLACE (State or foreign country) <b>New Castle Co., Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John Barkley</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Barkley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Charles Jackson Barkley - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Moderately advanced bilateral pulmonary tbc.</b> DUE TO (c) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 22, 1958</b> , to <b>February 10, 1960</b> , that I last saw the deceased alive on <b>February 10, 1960</b> , and that death occurred at <b>4:45 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edgars M. Maculans</b>		DATE SIGNED <b>2-10-60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. E. M. Maculans, Supt.</b>		<b>Henryton State Hospital Henryton, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-14-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Glass Hill Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Eden, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thornton B. Jolley</b>		24a. REC'D BY REGISTRAR <b>FEB 15 '60</b>	
ADDRESS <b>Salisbury Md</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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1803

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01790

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brookmont</u>	
c. LENGTH OF STAY IN IL <u>2 yrs 14 days</u>		d. STREET ADDRESS <u>6435 Brookes Lane</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield St. Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Margaret Irene BOOSE</u>		4. DATE OF DEATH Month <u>February</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WH.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-3-1889</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Gov't</u>	11. BIRTHPLACE (State or foreign country) <u>Washington, D. C.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Francis King</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Lolly</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Hospital Records, Springfield St. Hosp.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO <u>Generalized arteriosclerosis</u> (c) <u>Irreversible psychic reaction</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Irreversible psychic reaction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 18</u> , 19 <u>58</u> , to <u>Febr.</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-13-</u> , 19 <u>60</u> , and that death occurred at <u>8:05 P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Konstantin Weber</u> M.D.		ADDRESS (Street, city or town, state) <u>042 street at Short Hill Rd</u>	
DATE SIGNED <u>Feb 24 '60</u>		PHYSICIAN'S NAME (Type) <u>Konstantin WEBER M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/17/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Washington, D. C.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1804 CERTIFICATE OF DEATH

01791

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>8yrs.7mos.26days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
4. DATE OF DECEASED (Type or print) First <b>Lowell</b> Middle <b>Lewis</b> Last <b>Bosley</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1909</b>
9. AGE (In years lost birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Abraham Bosley</b>		14. MOTHER'S MAIDEN NAME <b>Lylia Huntermark</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute and chronic interstitial bilateral</b> <b>491X</b> DUE TO <b>bronchopneumonia.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-traumatic psychosis, post-traumatic deterioration.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>weeks</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 19, 1951</b> to <b>February 15, 1960</b> , that (I) (we) last saw the deceased alive on <b>February 15, 1960</b> , and that death occurred at <b>1:30PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>2/15/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 19, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		23d. LOCATION (City, town, or county) (State) <b>Black Rock Road, Butler, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24. ADDRESS <b>Reisterstown, Md.</b>	
25a. REC'D BY REGISTRAR DATE <b>FEB 19 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
FEDERAL BUREAU OF INVESTIGATION  
OFFICE OF THE ATTORNEY GENERAL  
DEPARTMENT OF JUSTICE  
WASHINGTON, D. C. 20535  
UNITED STATES OF AMERICA

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Manner of death: [illegible]  
6. Name of informant: [illegible]  
7. Address of informant: [illegible]  
8. Signature of informant: [illegible]  
9. Date of report: [illegible]  
10. Name of physician: [illegible]  
11. Address of physician: [illegible]  
12. Signature of physician: [illegible]  
13. Date of certificate: [illegible]  
14. Name of registrar: [illegible]  
15. Address of registrar: [illegible]  
16. Signature of registrar: [illegible]  
17. Date of registration: [illegible]  
18. Name of official: [illegible]  
19. Address of official: [illegible]  
20. Signature of official: [illegible]  
21. Date of filing: [illegible]

## CERTIFICATE OF DEATH

Reg. Dist. No.

01792

1795

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>				c. LENGTH OF STAY IN 1b <b>life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>202 E. Main Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Gertrude</b> Middle <b>Holbrook</b> Last <b>Bowers</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 5, 1875</b>	9. AGE (In years last birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>John Holbrook</b>				14. MOTHER'S MAIDEN NAME <b>Margaret (unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-03-6312</b>		17. INFORMANT Address <b>Charles H. Bowers Westminster, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocarditis</b> <b>590x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan. 30, 1960</b> , to <b>Feb. 11, 1960</b> , that I last saw the deceased alive on <b>Feb. 10, 1960</b> , and that death occurred at <b>7:25 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Wm. C. Jennette</b> M.D.				ADDRESS (Street, city or town, state) <b>103 E. Main Westminster, Md.</b> DATE SIGNED <b>2-12-60</b>			
PHYSICIAN'S NAME (Type) <b>W. C. Jennette, M.D.</b>		103 E. Main St. Westminster, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-14-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pleasant Valley, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers Westminster, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1797

## CERTIFICATE OF DEATH

01793

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll County</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster Md.</b>		c. LENGTH OF STAY IN 1b <b>35 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>32 Pennsylvania ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Francis Joseph Boylan</b>		4. DATE OF DEATH <b>Feb. II 19 60</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>4/25/85</b>
9. AGE (In years last birthday) <b>74 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>labeler</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>canning factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Patrick Boylan</b>		14. MOTHER'S MAIDEN NAME <b>Marie Ginnerty</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-01-3112</b>	
17. INFORMANT <b>sister Mrs Claude Mitten</b>		Address <b>RD#3 Westminster</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar Pneumonia</b> 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 10 -</b> , 19 <b>60</b> , to <b>Feb 11</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 11</b> , 19 <b>60</b> , and that death occurred at <b>8:30 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Westminster Md.</b> DATE SIGNED <b>2-11-60</b>			
ACTUAL SIGNATURE <b>James J. Marsh</b>		M.D. <b>JAMES T. MARSH</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>		<b>Westminster Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/13/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. John's Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Westminster, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James E. Saffell</b>		ADDRESS <b>Westminster, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1917

Carroll County

Married

Carroll County

Residence, Md.

Age, 52 yrs.

Sex, M.

22 Pennsylvania Ave.

22 Pennsylvania Ave.

Feb.

1917

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U.S.A.

Carroll Co. Maryland

Carroll County

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01794

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>3mos. 11 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>03X-2</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>8305 Harford Road, Zone 14</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nicholas Henry Brendel</u>				4. DATE OF DEATH Month Day Year <u>February 8, 1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 3, 1897</u>		9. AGE (In years lost birthday) yrs. <u>63</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Balto. Transit Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Brendel</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Herold</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes -1918, Pvt.-Army.</u>		16. SOCIAL SECURITY NO. <u>213-05-9014</u>		17. INFORMANT Address <u>Springfield Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Lobar Pneumonia</u> DUE TO <u>490X</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychotic depression.</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 24, 1959</u> to <u>February 8, 1960</u> that (I) (we) last saw the deceased alive on <u>February 7, 1960</u> , and that death occurred at <u>2:25 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Agustin del Campo</u> 22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2-11-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 10 '60</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Hanks</u>	

1903

CERTIFICATE OF DEATH

1903

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 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
 1805  
 Item 2 Film 227 2-25-60 et  
**CERTIFICATE OF DEATH**

01795

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> <b>Howard</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>	c. LENGTH OF STAY IN 1b <b>7mos. 24days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pattersonburg/ Daisy</b> <b>13X-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Asbury Methodist Home/</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>Lavinia</b> Last <b>Stier Brightwell</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 27, 1881</b>
9. AGE (In years lost birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.	IF UNDER 24 HRS. Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Rob Stier</b>	
14. MOTHER'S MAIDEN NAME <b>Eleanora Shipley</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with senile brain disease with psychotic reaction.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 24, 1959</b> to <b>Feb. 18, 1960</b> , that (I) (we) last saw the deceased alive on <b>Feb. 18, 1960</b> , and that death occurred at <b>2:55 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE SIGNED <b>2/18/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 20 - 60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Popular Spring Cemetery</b>	23d. LOCATION (City, town, or county) (State) <b>Harvard County Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. J. Salter</b>		25a. REC'D BY REGISTRAR <b>316 E. Diamond Ave. Pattersonburg, Md.</b>	25b. REGISTRAR'S SIGNATURE <b>W. J. Salter</b>
DATE <b>FEB 23 '60</b>			

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01796

Reg. Dist. No.

1807

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ingelsburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Windsor P.O.#1</u>			
c. LENGTH OF STAY IN 1b <u>10 hrs.</u>				d. STREET ADDRESS <u>Medford</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Westminster Md. RD.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JAMES ALFRED BROTHERS</u>				4. DATE OF DEATH <u>FEB. 9 1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 5, 1878</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <u>retired farmer &amp; carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>			
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Solomon Brothers</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Fowler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>				16. SOCIAL SECURITY NO. <u>214-01-0563</u>			
17. INFORMANT <u>Mrs. N. A. Entwistle, Union Bridge RD., Md.</u>				Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Sclerosis</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>James T. Marsh</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Brook Rural Westminster Md.</u>		22d. LOCATION (City, town, or county) (State) <u>  </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md.</u>				24a. REC'D BY REGISTRAR <u>  </u> 24b. REGISTRAR'S SIGNATURE <u>  </u>			
				DATE <u>FEB 11 '60</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1901

James Alfred

Brooklyn, N.Y.

John W.

Brooklyn, N.Y.

JAMES ALFRED BROTHERS

228

John Alfred

June 2, 1901

John Alfred

June 2, 1901

John Alfred

214-61-2333 John Alfred, June 2, 1901

John Alfred  
June 2, 1901

John Alfred

John Alfred

John Alfred

John Alfred

John Alfred

John Alfred

John Alfred

John Alfred  
June 2, 1901



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1808 CERTIFICATE OF DEATH

01797

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>--</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 weeks</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkins</b>		75 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Golden Age Nursing Home</b>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>IDA</b> Middle <b>S.</b> Last <b>CARGILL</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>6,</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 3, 1872</b>
9. AGE (In years lost birthday) yrs. <b>88</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Baton Rouge, La..</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Landry</b>		14. MOTHER'S MAIDEN NAME <b>Sinah Williams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>--</b>	
17. INFORMANT <b>Mrs. Ida. Weber, Ellicott City, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <b>Cerebral Hemorrhage</b> DUE TO (c) <b>Subarachnoid Hemorrhage</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>--</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Feb 2</b> 19 <b>60</b> to <b>Feb 6</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>Feb 2</b> 19 <b>60</b> and that death occurred at <b>3:40</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Donald L. Martin</b>		22b. DATE SIGNED <b>Feb. 7, 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. DONALD L. MARTIN</b>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 9, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ebenezer Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Carroll Co. Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.M. Waltz,</b>		25a. REC'D BY REGISTRAR <b>Winfield, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		25c. DATE <b>FEB 10 '60</b>	

DEPARTMENT OF HEALTH  
CENTRALS OF DEATH

1898

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1809 CERTIFICATE OF DEATH

01798

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>1 mos. 19 days</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Elihu</u> Last <u>Carlton</u>				4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1960</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 25, 1881</u>			
9. AGE (In years lost birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>					
13. FATHER'S NAME <u>John Carlton</u>				14. MOTHER'S MAIDEN NAME <u>Camelia Green</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-03-2556</u>					
17. INFORMANT <u>Springfield Hospital Records</u>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease.</u> DUE TO <u>Coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Old and recent myocardial infarct in left ventricle wall</u> (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u>Years</u> <u>Months &amp; years.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>September 15, 1959</u> to <u>February 4, 1960</u> , that (I) (we) last saw the deceased alive on <u>Feb. 3, 1960</u> , and that death occurred at <u>3:30 AM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Ellis S. Margolin</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2/11/60</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ellis S. Margolin, M.D.</u>				22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 6 - 60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Upper Cross Roads Baptist</u>		23d. LOCATION (City, town, or county) (State) <u>Baldwin Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Martin Glutz</u>				ADDRESS <u>Jarrettsville Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 8 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>									



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01799

1810

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>7 mo. 7 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>				d. STREET ADDRESS <b>403 Claybourne Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ellen Cahill</b> Last <b>Casey</b>				4. DATE OF DEATH Month <b>February</b> Day <b>1</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 21, 1863</b>	
9. AGE (In years last birthday) <b>96 yrs.</b>		IF UNDER 1 YEAR Months <b>96</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Michael Cahill</b>				14. MOTHER'S MAIDEN NAME <b>Josephine Ryan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral pneumonia</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 24, 1959</b> to <b>February 1, 1960</b> , that (I) (we) last saw the deceased alive on <b>Jan. 31, 1960</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edmund Lusthaus</b> M.D.				22b. DATE SIGNED <b>2/1/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>	
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2/4/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Pr. Geo. Co., Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co., 2901 14th St. N.W.</b>				25a. REC'D BY REGISTRAR <b>FEB 3 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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NAVY AND AIR DEPARTMENT OF MARYLAND  
CERTIFICATE OF DEATH

1218

1. Name of deceased: [illegible]  
2. Date of death: [illegible]  
3. Place of death: [illegible]  
4. Cause of death: [illegible]  
5. Age at death: [illegible]  
6. Sex: [illegible]  
7. Race: [illegible]  
8. Occupation: [illegible]  
9. Service: [illegible]  
10. Signature of physician: [illegible]  
11. Signature of registrar: [illegible]  
12. Date of registration: [illegible]



1811  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SPRESVILLE, R.D.</b>		c. LENGTH OF STAY IN 1b <b>6 WEEKS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GOLDEN AGE NURSING HOME - ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BERTHA C. COLWELL</b>		4. DATE OF DEATH Month Day Year <b>FEB 7 1960</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 16, 1885</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>WOODBINE, CARROLL Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN P. MILLER</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA E. BRICE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT Address <b>MRS. CASPER J. BEHR, WESTMINSTER, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterio Sclerotic Cardio-Vascular disease</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 10</b> , 19 <b>60</b> , to <b>Feb 7</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb 6</b> , 19 <b>60</b> , and that death occurred at <b>8:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>105 E. Main St</b> DATE SIGNED <b>2-8-60</b> ACTUAL SIGNATURE <b>James T. Marsh</b> M.D. <b>Westminster Md</b> PHYSICIAN'S NAME (Type or print) <b>JAMES T. MARSH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>FEB. 9, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>KRIDERS CEMETERY</b>	22d. LOCATION (City, town, or county) (State) <b>RURAL, WESTMINSTER, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. S. Myers, Jr., Westminster, Md.</b> ADDRESS <b>—</b>		24a. REC'D BY REGISTRAR <b>FEB 10 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. PLACE OF DEATH                  [Faint text]</p>	
<p>7. OCCUPATION                  [Faint text]</p>		<p>8. CAUSE OF DEATH                  [Faint text]</p>	
<p>9. MEDICAL HISTORY                  [Faint text]</p>		<p>10. MANNER OF DEATH                  [Faint text]</p>	
<p>11. SIGNATURE OF PHYSICIAN                  [Faint text]</p>		<p>12. SIGNATURE OF REGISTRAR                  [Faint text]</p>	
<p>13. DATE OF DEATH                  [Faint text]</p>		<p>14. TIME OF DEATH                  [Faint text]</p>	
<p>15. PLACE OF INTERMENT                  [Faint text]</p>		<p>16. NAME OF CEMETERY                  [Faint text]</p>	
<p>17. NAME OF FUNERAL HOME                  [Faint text]</p>		<p>18. NAME OF FUNERAL HOME                  [Faint text]</p>	
<p>19. NAME OF FUNERAL HOME                  [Faint text]</p>		<p>20. NAME OF FUNERAL HOME                  [Faint text]</p>	



THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01801

Reg. Dist. No.

1798

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER 27</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>N. CENTER ST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LOTTIE</u> First Middle Last <u>ISADORE CRUMBACKER</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>12</u> Year <u>1960</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 23-1895</u> 85 yrs.
9. AGE (In years last birthday) <u>85</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER AT HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN CAMPBELL</u>		14. MOTHER'S MAIDEN NAME <u>RACHAEL FLICKINGER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-18-1243</u>	
17. INFORMANT <u>HARRY K CRUMBACKER</u> Address <u>WESTMINSTER MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 <u>Coronary</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs + 8 mos</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>May</u> 19 <u>52</u> , to <u>Feb 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Feb 11</u> , 19 <u>60</u> , and that death occurred at <u>8</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>15 Kemper ave. Westminister, Md.</u> DATE SIGNED <u>2/12/60</u>			
ACTUAL SIGNATURE <u>Dr. Reese Wilkens</u> M.D.		DATE SIGNED <u>2/12/60</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Reese Wilkens</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BRETHREN CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>Rocky Ridge, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>D.D. Hartzler</u> ADDRESS <u>Union Bridge Md</u>		24a. REC'D BY REGISTRAR <u>Arthur S. Hines</u> DATE <u>FEB 16 '60</u>	24b. REGISTRAR'S SIGNATURE

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

01802

1812

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Washington, D.C.</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Arthur Douglas Cutts</b>				4. DATE OF DEATH <b>Febr. 6th 19 60</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>3/17/1886</b>	
9. AGE (In years last birthday) <b>73</b>		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min. <b>73</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Rec. in Treas. Dept</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>James M. Cutts</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. Wheeler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>X</b>		16. SOCIAL SECURITY NO. <b>X</b>		INFORMANT <b>Records of Springfield State Hospital</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic alcoholism, Korsakow's</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1st 1953</b> to <b>Febr 5th 1960</b> , that I last saw the deceased alive on <b>Febr 6th 1960</b> , and that death occurred at <b>8:55 a.m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Spring, Sta. hsp.</b> DATE SIGNED <b>2-6-60</b>							
ACTUAL SIGNATURE <b>Myron Nizankowsky</b> M.D.				PHYSICIAN'S NAME (Type) <b>Myron Nizankowsky</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/9/60</b>		22b. DATE THEREOF <b>2/9/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Falls Church, Virginia</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H.Hines Co., 2901 14th St. N.W.</b> ADDRESS <b>Wash, D.C.</b>				24a. REC'D BY REGISTRAR <b>FEB 9 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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Blank form with faint horizontal lines and some illegible handwritten text at the bottom.



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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01803

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Middleburg</b>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Middleburg</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <b>Sherry Anne Dedmon</b>			4. DATE OF DEATH Month <b>February</b> Day <b>27</b> Year <b>1960</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 8, 1959</b>		9. AGE (In years last birthday) <b>1</b> yrs. <b>4</b> Months <b>1</b> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Hanover Hopt. Hanover Pa, U.S.A.</b>	
13. FATHER'S NAME <b>Alfred D. Dedmon</b>			14. MOTHER'S MAIDEN NAME <b>Nancy Lou Scott</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Alfred D. Dedmon, Middleburg Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>493X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2/28/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>March 1, 60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>	
23. FUNERAL DIRECTOR <b>J. E. Myers Jr. Westminster, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>DATE MAR 2 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		24c. LOCATION (City, town, or country) (State) <b>Uniontown Carroll Co. Md.</b>			

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FOR STATE  
DEPT. OF JUSTICE

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1913

UNITED STATES DEPARTMENT OF JUSTICE

Division

Division

Division

January 27 1900

January 27 1900

Division

1913

Division

1913

## 1814 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Middleburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Middleburg</u>	
c. LENGTH OF STAY IN 1b <u>3 weeks</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Brookfield Manor</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>GEORGE - H - DIEHL</u>		4. DATE OF DEATH <u>February 23 1960</u>	
S. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Mar 2-1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>W S A</u>	
13. FATHER'S NAME <u>Harry Diehl</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mrs Helen Stoner</u>		Address <u>Hampstead Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC MYOCARDITIS</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>FEB. 16</u> , 19 <u>60</u> , to <u>FEB. 23</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>FEB. 22</u> , 19 <u>60</u> , and that death occurred at <u>9:45</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Union Bridge, MD</u> DATE SIGNED <u>2-23-60</u>			
ACTUAL SIGNATURE <u>Thomas H. Legg</u> M.D.		PHYSICIAN'S NAME (Type) <u>Thomas H. Legg, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-26-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Chipton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 26 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01805

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pa.</b> b. COUNTY <b>York</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Datour</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>York - Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>RD#8</b>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Coulson</b> Last <b>Dohm</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>25</b> Year <b>1960</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-6-1921</b>	9. AGE (In years last birthday) <b>38</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sewing Machine Op.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Mfg.</b>		11. BIRTHPLACE (State or foreign country) <b>Hanover, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Roy Coulson</b>				14. MOTHER'S MAIDEN NAME <b>Mary Bair</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>183-18-7648</b>		17. INFORMANT <b>George J. Dohm</b> <b>Reynolds Mill Rd. York RD#8, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinometastasis</b> <b>153.8</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma - Colon - Original Site.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/1/60</b> , 19 <b>60</b> , to <b>2/25/60</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>2/25/60</b> , 19 <b>60</b> , and that death occurred at <b>7 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>M. E. Robertson</b> M.D. <b>New Windsor, Md.</b> <b>2/25/60</b>							
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>2-28-1960</b>		<b>York Rd. Cemetery</b>		<b>Hanover, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dennis R. G. Metzger</b>				ADDRESS <b>542 Carlisle St. Hanover Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 1 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE UNIVERSITY OF CHICAGO



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01806

1816 **CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Sykesville</i>	
3. NAME OF DECEASED (Type or print) <i>FANNIE ARDEEN DUVALL</i> First Middle Last		4. DATE OF DEATH <i>Feb 16 1960</i> Month Day Year	
5. SEX <i>Female</i>	6. COLOR OF RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 27 1875</i>
9. AGE (In years last birthday) <i>84</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George W. Mosley</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Baker</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs Alfred Winter - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage.</i> 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertension.</i> (c) <i>Generalized Arteriosclerosis.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Sudden.</i> <i>Years.</i> <i>Years.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Ch. Heart failure.</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>—</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Aug 27 1957</i> to <i>Feb 16 1960</i> , that (I) (we) last saw the deceased alive on <i>Jan 16 1960</i> , and that death occurred on <i>Feb 16 1960</i> at <i>PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Sani Okutman</i> M.D.		22b. DATE SIGNED <i>Feb 17 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>Sani Okutman</i>		22d. ADDRESS <i>Sykesville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>2-19-60</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Montgomery Chapel</i>	23d. LOCATION (City, town, or county) (State) <i>near Damascus, Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Haight</i> ADDRESS <i>Sykesville, Md.</i>		25a. REC'D BY REGISTRAR DATE <i>FEB 23 '60</i>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur H. Haight</i>	

1918

RECEIVED  
THE DEPARTMENT OF THE ARMY  
WASHINGTON, D. C.  
JAN 10 1918

1918



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1799

## CERTIFICATE OF DEATH

01807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>27 Westminster, Md.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>169 W. Main, St.</b>		d. STREET ADDRESS <b>169 W. Main, St.</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>CLIFFORD V. ESWORTHY</b>		4. DATE OF DEATH Month Day Year <b>February 1, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 10, 1914</b> 45 yrs.
9. AGE (In years last birthday) <b>45</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Route Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carroll Dist.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Howard Esworthy</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Helen Black</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes W.W. 11</b>		16. SOCIAL SECURITY NO. <b>215-26-1503</b>	
17. INFORMANT <b>Mrs. Ella M. Mc Cormick,</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>65 hrs +</b>			INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>8-17-</b> 19 <b>59</b> , to <b>Feb 1</b> 19 <b>60</b> ; that I last saw the deceased alive on <b>Jan 15</b> 19 <b>60</b> , and that death occurred at <b>8:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10 SE Shaw St</b> DATE SIGNED <b>2/1/60</b> ACTUAL SIGNATURE <b>James J. Sharoh</b> M.D. PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 4, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Locust Grove Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Frederick, Co. Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 4 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hound</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH COUNTY		DEATH RECORD NO.	
DATE OF DEATH		TIME OF DEATH	
PLACE OF BIRTH		DATE OF BIRTH	
SEX		COLOR	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL ATTENDANCE	
NAME OF DECEASED		NAME OF NEXT OF KIN	
ADDRESS OF DECEASED		ADDRESS OF NEXT OF KIN	
CITY AND STATE		CITY AND STATE	
SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER	
SIGNATURE OF JUDGE		SIGNATURE OF CLERK	

This certificate is to be filled out by the physician or coroner who has examined the body of the deceased and has determined the cause of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

## 1817 CERTIFICATE OF DEATH

01808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN 1b <b>1,057 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Lee</b> Last <b>Faison</b>				4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-6-24</b>	9. AGE (In years last birthday) <b>35</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Farmville, N. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Faison</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>227-26-0680</b>		INFORMANT <b>Arthur Faison - Patient</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cor-Pulmonale</b> DUE TO (c) <b>Far advanced bilateral pulmonary tbc.</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 20, 1957</b> , to <b>February 10, 1960</b> , that I last saw the deceased alive on <b>February 10, 1960</b> , and that death occurred at <b>4:50 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edgar M. Maculans M.D.</b>		M.D.		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>		DATE SIGNED <b>2-10-60</b>	
PHYSICIAN'S NAME (Type) <b>Dr. E. M. Maculans, Supt.</b>		HENRYTON STATE HOSPITAL HENRYTON, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb 13, 1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Neaport (Baltimore) Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph S. Russ</b>				ADDRESS <b>2222 W. North Ave</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Source: 2 Rev. 2. 2222 in North Ave



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

# CERTIFICATE OF DEATH

01809

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>	
c. LENGTH OF STAY IN 1b <i>10 years</i>		d. STREET ADDRESS <i>Wilson Ave.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>CLARA</i> First <i>ARMINTA</i> Middle <i>FITZEE</i> Last		4. DATE OF DEATH Month <i>Feb.</i> Day <i>3</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 23, 1882</i>
9. AGE (In years last birthday) <i>77</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Scott Waddell</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Herman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Mrs. James Riblett - Sykesville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure, arteriosclerotic heart</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>disease, arteriosclerosis generalized, arthritis</i> DUE TO (c) <i>Bronchial pneumonia.</i> INTERVAL BETWEEN ONSET AND DEATH <i>1954 to 3 Jan 60</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1954</i> 19 to <i>3 Jan</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>3 Jan</i> 19 <i>60</i> , and that death occurred at <i>7:38</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard E. Hall</i>		22b. DATE SIGNED <i>2/4/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		22d. ADDRESS <i>Sykesville, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-6-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Meadow Branch</i>		23d. LOCATION (City, town, or county) (State) <i>Westminster, Carroll Co., Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Haight</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Haight</i>	
ADDRESS <i>Sykesville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Haight</i>	
DATE <i>FEB 9 '60</i>			

10-21-58

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF PUBLIC HEALTH  
DIVISION OF VITAL STATISTICS  
STATE OF CALIFORNIA  
1958

1958



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1819 CERTIFICATE OF DEATH

Reg. Dist. No.

01810

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Westminster, R. D. 1 (Silver Run)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emma J. Fitze</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>In her own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Adam Yingling</b>		14. MOTHER'S MAIDEN NAME <b>Almeda Burgoon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Charles A. Leppo, Westminster, Md. R.D.1</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>174x Carcinoma of Uterus with metastasis</b> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 13, 1957</b> , to <b>February 23, 1960</b> , that I last saw the deceased alive on <b>February 20, 1960</b> , and that death occurred at <b>2:40 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>12 W. KING ST. LITTLESTOWN, PA 22460</b> DATE SIGNED ACTUAL SIGNATURE <b>L. L. Potter</b> M.D. PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D. 12 W. KING ST. LITTLESTOWN, PA</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/26/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Silver Run, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		ADDRESS <b>Littlestown, Pa.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 25 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b> c. LENGTH OF STAY IN lb <b>618 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. George's</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beltsville</b> d. STREET ADDRESS <b>5516 Odell Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Gaither</b>		4. DATE OF DEATH Month Day Year <b>Feb. 5, 1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-13-1882</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>77</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Hospital Record - Pr. George's County, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency. Assian Flu</b> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Far advanced bilateral pulmonary Tbc.</b> (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Mar. 17, 1958</b> to <b>Feb. 5, 1960</b> , that I last saw the deceased alive on <b>Feb. 5, 1960</b> , and that death occurred at <b>6:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>2-5-60</b> ACTUAL SIGNATURE <b>Edgars M. Maculans</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-10-60</b>		22b. DATE THEREOF <b>2-10-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Queens Chapel Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Muirkirk Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry S. Washington</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

VS A15 (4)  
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled in by the funeral director, and page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and fill with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK

1880

11

IN SENATE,  
January 12, 1880.  
REPORT  
OF THE  
COMMISSIONERS OF THE LAND OFFICE,  
IN ANSWER TO A RESOLUTION PASSED BY THE SENATE,  
MAY 17, 1879.  
ALBANY:  
J. B. LEECH, PRINTER.  
1880.



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01812

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Carroll</u> MARYLAND</p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u></p> <p>c. LENGTH OF STAY IN 1b <u>2 m 8 days</u></p> <p>d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</p> <p>a. STATE <u>Maryland</u> b. COUNTY <u>City</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 23, Md.</u></p> <p>d. STREET ADDRESS <u>1129 <del>Gardner</del> Street</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>James</u> Middle <u></u> Last <u>Gardiner</u></p>			<p>4. DATE OF DEATH</p> <p>Month <u>2</u> Day <u>5</u> Year <u>19 60</u></p>				
<p>5. SEX <u>Male</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			
<p>8. DATE OF BIRTH <u>3-25-88</u></p>		<p>9. AGE (In years lost birthday) <u>71</u> yrs.</p>		<p>IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u></p> <p>IF UNDER 24 HRS. Hours <u></u> Min. <u></u></p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u></u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>			
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>							
<p>13. FATHER'S NAME <u>Charles Gardiner</u></p>			<p>14. MOTHER'S MAIDEN NAME <u>Catherine Lyons</u></p>				
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u></p>		<p>16. SOCIAL SECURITY NO. <u>unkn</u></p>		<p>17. INFORMANT <u>Hospital Records</u> Address <u></u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Bilateral pulmonary Tuberculosis, far advanced</u></p> <p>DUE TO (b) <u></u></p> <p>Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u>lying cause last. (c) <u></u></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>C.B.S. assoc. with cerebral arterioscler. with psych. reaction, late latent syphilis</u></p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p> <p>20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u></p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p> <p>20f. (City or town) (County) (State)</p>							
<p>21. I certify that (I) (this hospital) attended the deceased from <u>11-27-</u> <u>19 59</u> to <u>2-5-</u> <u>19 60</u> that (I) (we) last saw the deceased alive on <u>2-5-</u> <u>19 60</u>, and that death occurred at <u>8: PM</u>, from the causes and on the date stated above.</p> <p>22a. SIGNATURE <u>Edmund Lusthaus</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>2-6-60</u></p> <p>22c. PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u> 22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u></p>							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE THEREOF <u>Feb. 9, 1960</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u></p>			
<p>23d. LOCATION (City, town, or county) <u>Baltimore</u> (State) <u></u></p>							
<p>24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Cole</u> ADDRESS <u>1913 W. Baltimore St</u></p>			<p>25a. REC'D BY REGISTRAR <u>DATE FEB 8 '60</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>C. L. K. K. K.</u></p>		

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Ce 3-2100

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1822 CERTIFICATE OF DEATH

Reg. Dist. No.

01813

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN lb <b>973 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>307 Lennox Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Calvin</b> Middle <b>Wilmer</b> Last <b>Gardner</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1915</b>
9. AGE (In years lost birthday) yrs. <b>44</b>		10. IF UNDER 1 YEAR Months <b>44</b> Days <b>44</b> Hours <b>44</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Whitehall, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U. S. A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>George W. Gardner</b>		14. MOTHER'S MAIDEN NAME <b>Annie M. Givens</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-01-4223</b>	
INFORMANT <b>Calvin W. Gardner - Patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far Advanced Bilateral Pulmonary Tuberculosis with Cavitation right</b> 002X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12, 1957</b> to <b>February 10, 1960</b> , that I last saw the deceased alive on <b>February 10, 1960</b> , and that death occurred at <b>7:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Henryton, Maryland 2-10-60</b> ACTUAL SIGNATURE <b>Edgers M. Maculans M.D.</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. E. M. Maculans, Supt.</b> <b>Henryton State Hospital, Henryton, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-17-60</b>		22b. DATE THEREOF <b>2-17-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wm. Annapolis Bury</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Howell</b>		24a. REC'D BY REGISTRAR <b>Feb 18 '60</b>	
ADDRESS <b>Pikes &amp;</b>		24b. REGISTRAR'S SIGNATURE <b>Wm. S. Thoms</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death.

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1. *Journal of the American Medical Association*, 1997; 278: 1039-1044.

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01814

1823

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>2yr. 10mo. 21days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>610 Oldham Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Luigi - Giordano</b>				4. DATE OF DEATH Month Day Year <b>February 23 1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>October 12, 1883</b>	
9. AGE (In years lost birthday) <b>76 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Construction</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield Hospital records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriolar nephrosclerosis.</b> <b>446X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction</b> <b>Late latent syphilis</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>028.1</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1</b> 19 <b>58</b> to <b>February 23</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>February 23</b> 19 <b>60</b> and that death occurred at <b>9:20 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				22b. DATE SIGNED <b>2/23/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo</b>	
22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-25-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Wright</b>				25a. REC'D BY REGISTRAR <b>FEB 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Trans</b>	

**Springfield State Hospital, Sykesville, Md.**

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



MEDICAL CERTIFICATION

VS A15 (4)  
15M 10/57







01817

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		1826		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10yrs. 4mos. 25days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		<b>3701.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>- Park Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Nathan</b>		Middle <b>Charles</b>		Last <b>Hammond</b>	
4. DATE OF DEATH		Month <b>February</b>		Day <b>8</b>		Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1875</b>		9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Selling chickens</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poultry</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathan Hammond</b>		14. MOTHER'S MAIDEN NAME <b>Alice -</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>491X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Semile psychosis, simple deterioration.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 7, 1955</b> to <b>Feb. 8, 1960</b> , that (I) (we) last saw the deceased alive on <b>February 8, 1960</b> , and that death occurred at <b>3:40 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				22b. DATE SIGNED <b>2/9/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>	
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2/15/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Haight</b>				25a. REC'D BY REGISTRAR <b>FEB 17 1960</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Haight</b>	



1988





## 1827 CERTIFICATE OF DEATH

Reg. Dist. No.

01818

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>8mos. 18days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSPITAL</b>				d. STREET ADDRESS <b>1822 North Charles Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Ethel</b> Last <b>HANSON</b>				4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-14-1880</b>	
9. AGE (In years lost birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Charles Hanson</b>				14. MOTHER'S MAIDEN NAME <b>Mary A. Adams</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>S.S.H. Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>  <b>Years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May 20</b> , 19 <b>59</b> , to <b>February 8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>February 7</b> , 19 <b>60</b> , and that death occurred at <b>3:20AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2-8-60</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M. D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-10-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b>				ADDRESS <b>5305 Harford Rd</b>			
24a. REC'D BY REGISTRAR DATE <b>FEB 10 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>			

1

hours after death. Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filled with the information required by the funeral director. Pages 3 and 4 should be filled with the information required by the funeral director. Pages 1 and 2 should be filled with the information required by the funeral director. Pages 3 and 4 should be filled with the information required by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the information required by the funeral director. Pages 3 and 4 should be filled with the information required by the funeral director.

VS A15 (4)  
15M 9/58

11118

1867 - CERTIFICATE OF DEATH

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to fading and bleed-through from the reverse side of the page.

1828

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hampstead</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>JOHN - T - HARRIS</u> First Middle Last				4. DATE OF DEATH <u>Feb 2</u> Month Day Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 26 - 1877</u>		9. AGE (In years lost birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William M Harris</u>				14. MOTHER'S MAIDEN NAME <u>Mary Blizzard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-18-4306</u>		INFORMANT <u>Catherine L. Wolfe - Hampstead Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>10 min</u> <u>8 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Old Cerebral Thrombosis</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>58</u> , to <u>February 2, 1960</u> , and that death occurred at <u>3p</u> M, from the causes and on the date stated above. alive on <u>February 1</u> , 19 <u>60</u> , and that death occurred at <u>3p</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u> DATE SIGNED <u>2/2/60</u>							
ACTUAL SIGNATURE <u>M.C. Porterfield</u>				PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-6-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Manchester</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u>				ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>Arthur L. Huns</u>	
				DATE <u>FEB 5 '60</u>		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1919

1232

CERTIFICATE OF DEATH

Decedent's Name: *John T. Harris*

Age: *45*

Sex: *Male*

Place of Birth: *Johns Hopkins*

Occupation: *Physician*

Usual Residence: *Johns Hopkins*

Date of Death: *Jan 15 1919*

Time of Death: *10:15 AM*

Place of Death: *Johns Hopkins*

Cause of Death: *Myocardial Infarction*

Manner of Death: *Natural*

Signature of Physician: *John T. Harris*

Signature of Coroner: *John T. Harris*

Signature of Registrar: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Medical Examiner: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

Signature of Burial Officer: *John T. Harris*

Signature of Health Officer: *John T. Harris*

Signature of Public Health Officer: *John T. Harris*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1829

## CERTIFICATE OF DEATH

Reg. Dist. No. **74**

01820

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <span style="float: right;">b. COUNTY</span>								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>			c. LENGTH OF STAY IN 1b <b>4 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>2108 N. Rosedale St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Douglas</b> Middle <b>Hawkins</b> Last <b>Hawkins</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>19</b> Year <b>19 60</b>								
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-16-1887</b>		9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Charles Co., Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Dennis Hawkins</b>						14. MOTHER'S MAIDEN NAME <b>Nettie ??</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>213-07-3172</b>		INFORMANT Address <b>Bertha Swann 2108 Rosedale Street</b>						
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Virus pneumonia and tuberculosis left</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
<b>21. I certify</b> that I attended the deceased from <b>February 15 19 60</b> , to <b>Feb. 19 19 60</b> , that I last saw the deceased alive on <b>Feb. 19 19 60</b> , and that death occurred at <b>12 Noon</b> M, from the causes and on the date stated above.												
ACTUAL SIGNATURE <b>Edgars M. Maculans M.D.</b> M.D.						ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>			DATE SIGNED <b>2-19-60</b>			
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D.</b>						<b>Henryton State Hospital</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>2-25-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>			22d. LOCATION (City, town, or county) (State) <b>A. D. Co. Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Johnson</b>						ADDRESS <b>1700 Davis St. Baltimore</b>			24a. REC'D BY REGISTRAR DATE <b>FEB 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Thomas</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1822

CERTIFICATE OF DEATH

State of New York  
County of ...  
I, the undersigned, a Justice of the Peace for the County of ...  
do hereby certify that on the ... day of ... 1822  
at ... in the County of ...  
the following named person died to-wit:

Name of Deceased ...  
Age ...  
Sex ...  
Color ...  
Cause of Death ...

Witnessed by me, the undersigned, on the ... day of ... 1822  
at ... in the County of ...

Subscribed and sworn to before me on the ... day of ... 1822  
at ... in the County of ...

My Commission Expires on the ... day of ... 1822

Notary Public for the County of ...

State of New York  
County of ...  
I, the undersigned, a Justice of the Peace for the County of ...  
do hereby certify that on the ... day of ... 1822  
at ... in the County of ...  
the following named person died to-wit:

Name of Deceased ...  
Age ...  
Sex ...  
Color ...  
Cause of Death ...

Witnessed by me, the undersigned, on the ... day of ... 1822  
at ... in the County of ...



1830

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

01821

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr 5 m 10 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ella</b> Middle <b>Josephine</b> Last <b>Himmighoefer</b>		4. DATE OF DEATH Month <b>2</b> Day <b>6</b> Year <b>19 60</b>	
5. SEX <b>Fem</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-23-1881</b>
9. AGE (In years and birth day) yrs. <b>79</b>		10. IF UNDER 1 YEAR Months <b>10</b> Days <b>13</b> Hours <b></b> Min. <b></b>	11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Missouri</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Philipp Jacobs</b>		14. MOTHER'S MAIDEN NAME <b>Sophie Kettlekamp</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>unkn</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic heart disease, inactive, with mitral sten.</b> DUE TO (b) <b>410X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <b></b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circulat. disturbance with cerebral arteriosclerosis with psych. reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8-26-58</b> 19 <b>58</b> to <b>2-6-</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>2-6-</b> 19 <b>60</b> , and that death occurred at <b>5:20 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edmund Lusthaus</b>		22b. DATE SIGNED <b>2-7-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-10-60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l Cem.</b>	23d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey, Bethesda, Maryland</b>		25. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

1021

DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

01822

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md RD #1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster Md RD #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Mills</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE WILLIAM HOOK</u>		4. DATE OF DEATH Month Day Year <u>FEB. 10 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 27 1883</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>formal painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George William Hook</u>		14. MOTHER'S MAIDEN NAME <u>Catherine ?</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Walter H. Hook, Westminster RD #1 Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocarditis and myocardial degeneration</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Bronchitis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-9</u> , 19 <u>57</u> , to <u>2-10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-10</u> , 19 <u>60</u> , and that death occurred at <u>2:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>R. L. Potter M.D.</u> M.D. <u>12 W. KING ST. LITTLESTOWN, PA</u> <u>2-10-60</u> PHYSICIAN'S NAME (Type) <u>L. L. POTTER M.D.</u> <u>12 W. KING ST. LITTLESTOWN, PA</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/12/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery Union Mills Westminster Md</u>	22d. LOCATION (City, town, or county) (State) <u>Westminster Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr. Westminster, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

See DM 44

<p>1. NAME OF DECEASED                  [Illegible Name]</p>		<p>2. SEX                  [Illegible]</p>	
<p>3. AGE                  [Illegible]</p>		<p>4. DATE OF BIRTH                  [Illegible]</p>	
<p>5. PLACE OF BIRTH                  [Illegible]</p>		<p>6. OCCUPATION                  [Illegible]</p>	
<p>7. MARITAL STATUS                  [Illegible]</p>		<p>8. COLOR                  [Illegible]</p>	
<p>9. PLACE OF DEATH                  [Illegible]</p>		<p>10. CAUSE OF DEATH                  [Illegible]</p>	
<p>11. TIME OF DEATH                  [Illegible]</p>		<p>12. SIGNATURE OF DECEASED                  [Illegible]</p>	
<p>13. SIGNATURE OF WITNESS                  [Illegible]</p>		<p>14. SIGNATURE OF PHYSICIAN                  [Illegible]</p>	
<p>15. SIGNATURE OF CLERK                  [Illegible]</p>		<p>16. SIGNATURE OF JURY                  [Illegible]</p>	
<p>17. SIGNATURE OF JURY                  [Illegible]</p>		<p>18. SIGNATURE OF JURY                  [Illegible]</p>	
<p>19. SIGNATURE OF JURY                  [Illegible]</p>		<p>20. SIGNATURE OF JURY                  [Illegible]</p>	
<p>21. SIGNATURE OF JURY                  [Illegible]</p>		<p>22. SIGNATURE OF JURY                  [Illegible]</p>	
<p>23. SIGNATURE OF JURY                  [Illegible]</p>		<p>24. SIGNATURE OF JURY                  [Illegible]</p>	
<p>25. SIGNATURE OF JURY                  [Illegible]</p>		<p>26. SIGNATURE OF JURY                  [Illegible]</p>	
<p>27. SIGNATURE OF JURY                  [Illegible]</p>		<p>28. SIGNATURE OF JURY                  [Illegible]</p>	
<p>29. SIGNATURE OF JURY                  [Illegible]</p>		<p>30. SIGNATURE OF JURY                  [Illegible]</p>	
<p>31. SIGNATURE OF JURY                  [Illegible]</p>		<p>32. SIGNATURE OF JURY                  [Illegible]</p>	
<p>33. SIGNATURE OF JURY                  [Illegible]</p>		<p>34. SIGNATURE OF JURY                  [Illegible]</p>	
<p>35. SIGNATURE OF JURY                  [Illegible]</p>		<p>36. SIGNATURE OF JURY                  [Illegible]</p>	
<p>37. SIGNATURE OF JURY                  [Illegible]</p>		<p>38. SIGNATURE OF JURY                  [Illegible]</p>	
<p>39. SIGNATURE OF JURY                  [Illegible]</p>		<p>40. SIGNATURE OF JURY                  [Illegible]</p>	
<p>41. SIGNATURE OF JURY                  [Illegible]</p>		<p>42. SIGNATURE OF JURY                  [Illegible]</p>	
<p>43. SIGNATURE OF JURY                  [Illegible]</p>		<p>44. SIGNATURE OF JURY                  [Illegible]</p>	
<p>45. SIGNATURE OF JURY                  [Illegible]</p>		<p>46. SIGNATURE OF JURY                  [Illegible]</p>	
<p>47. SIGNATURE OF JURY                  [Illegible]</p>		<p>48. SIGNATURE OF JURY                  [Illegible]</p>	
<p>49. SIGNATURE OF JURY                  [Illegible]</p>		<p>50. SIGNATURE OF JURY                  [Illegible]</p>	
<p>51. SIGNATURE OF JURY                  [Illegible]</p>		<p>52. SIGNATURE OF JURY                  [Illegible]</p>	
<p>53. SIGNATURE OF JURY                  [Illegible]</p>		<p>54. SIGNATURE OF JURY                  [Illegible]</p>	
<p>55. SIGNATURE OF JURY                  [Illegible]</p>		<p>56. SIGNATURE OF JURY                  [Illegible]</p>	
<p>57. SIGNATURE OF JURY                  [Illegible]</p>		<p>58. SIGNATURE OF JURY                  [Illegible]</p>	
<p>59. SIGNATURE OF JURY                  [Illegible]</p>		<p>60. SIGNATURE OF JURY                  [Illegible]</p>	
<p>61. SIGNATURE OF JURY                  [Illegible]</p>		<p>62. SIGNATURE OF JURY                  [Illegible]</p>	
<p>63. SIGNATURE OF JURY                  [Illegible]</p>		<p>64. SIGNATURE OF JURY                  [Illegible]</p>	
<p>65. SIGNATURE OF JURY                  [Illegible]</p>		<p>66. SIGNATURE OF JURY                  [Illegible]</p>	
<p>67. SIGNATURE OF JURY                  [Illegible]</p>		<p>68. SIGNATURE OF JURY                  [Illegible]</p>	
<p>69. SIGNATURE OF JURY                  [Illegible]</p>		<p>70. SIGNATURE OF JURY                  [Illegible]</p>	
<p>71. SIGNATURE OF JURY                  [Illegible]</p>		<p>72. SIGNATURE OF JURY                  [Illegible]</p>	
<p>73. SIGNATURE OF JURY                  [Illegible]</p>		<p>74. SIGNATURE OF JURY                  [Illegible]</p>	
<p>75. SIGNATURE OF JURY                  [Illegible]</p>		<p>76. SIGNATURE OF JURY                  [Illegible]</p>	
<p>77. SIGNATURE OF JURY                  [Illegible]</p>		<p>78. SIGNATURE OF JURY                  [Illegible]</p>	
<p>79. SIGNATURE OF JURY                  [Illegible]</p>		<p>80. SIGNATURE OF JURY                  [Illegible]</p>	
<p>81. SIGNATURE OF JURY                  [Illegible]</p>		<p>82. SIGNATURE OF JURY                  [Illegible]</p>	
<p>83. SIGNATURE OF JURY                  [Illegible]</p>		<p>84. SIGNATURE OF JURY                  [Illegible]</p>	
<p>85. SIGNATURE OF JURY                  [Illegible]</p>		<p>86. SIGNATURE OF JURY                  [Illegible]</p>	
<p>87. SIGNATURE OF JURY                  [Illegible]</p>		<p>88. SIGNATURE OF JURY                  [Illegible]</p>	
<p>89. SIGNATURE OF JURY                  [Illegible]</p>		<p>90. SIGNATURE OF JURY                  [Illegible]</p>	
<p>91. SIGNATURE OF JURY                  [Illegible]</p>		<p>92. SIGNATURE OF JURY                  [Illegible]</p>	
<p>93. SIGNATURE OF JURY                  [Illegible]</p>		<p>94. SIGNATURE OF JURY                  [Illegible]</p>	
<p>95. SIGNATURE OF JURY                  [Illegible]</p>		<p>96. SIGNATURE OF JURY                  [Illegible]</p>	
<p>97. SIGNATURE OF JURY                  [Illegible]</p>		<p>98. SIGNATURE OF JURY                  [Illegible]</p>	
<p>99. SIGNATURE OF JURY                  [Illegible]</p>		<p>100. SIGNATURE OF JURY                  [Illegible]</p>	

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may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1832

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01823

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>1yr. 4mo. 20days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>825 N. Mount Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sarah - Hare Isaacson</b>				4. DATE OF DEATH Month Day Year <b>February 19 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 18, 1864</b>	
9. AGE (In years lost birthday) <b>95</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Alien (Russia)</b>							
13. FATHER'S NAME <b>Samuel Hare</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with cerebral arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March 7 1955</b> to <b>February 19 1960</b> , that (I) (we) last saw the deceased alive on <b>February 19 1960</b> , and that death occurred at <b>3:46 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/19/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-21-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>HERRING RUN</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO. MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jack Lewis Inc - 2105 EUTAW PLACE</b>				ADDRESS <b>2105 EUTAW PLACE</b>		25a. REC'D BY REGISTRAR <b>FEB 23 '60</b>	
				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>			







# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01824

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> <b>1800</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster</b> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>328 E. MAIN Street</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>27 Westminster</b> d. STREET ADDRESS <b>328 E. MAIN Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MILDRED</b> Middle <b>RAYBINE</b> Last <b>JACOBS</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>26</b> Year <b>19 60</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 21, 1897</b>		<b>9. AGE</b> (In years last birthday) <b>62</b> yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>house wife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Carroll Co. Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Levi T. Truzzell</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Barber</b>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <input type="checkbox"/> <b>16. SOCIAL SECURITY NO.</b> <input type="checkbox"/> <b>17. INFORMANT</b> <b>Mrs. Alice L. Brown</b> Address <b>503 E. Main St. Westminster, Md.</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease.</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Acute Alcoholism.</b> (b) <input type="checkbox"/> (c) <input type="checkbox"/> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <input type="checkbox"/> o. m. <input type="checkbox"/> p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
<b>ACTUAL SIGNATURE</b> <b>Charles S. Petty</b> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b> <b>2/27/60</b>	
<b>EXAMINER'S NAME (Type)</b> <b>Charles S. Petty, M.D.</b>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>22b. DATE THEREOF</b> <b>Feb. 29, 1960</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Westminster Cemetery</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Westminster, Md.</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>J. E. Meyer, Jr. Westminster, Md.</b>				<b>24a. REC'D BY REGISTRAR</b> <b>MAR 3 1960</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur L. Howard</b>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1833 CERTIFICATE OF DEATH

01825

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Ind</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockdale</u> 03X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weitzel Nursing Home</u>		e. STREET ADDRESS <u>8401 Charnel Drive</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>J</u> Last <u>JEAN</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 7, 1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Co., Ind</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter H. Odel</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Doubleday</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-05-8407B</u>	
17. INFORMANT <u>Gordon Power</u> Address <u>34 Chesapeake Ave</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Rectum, pelvic metastases, 154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>anemia, senile degeneration, leukemia</u> DUE TO (c) <u>failure - bronchial pneumonia</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>1951 to 18 Feb 60</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1959</u> , 19 <u>60</u> , to <u>18 Feb</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>18 Feb</u> , 19 <u>60</u> , and that death occurred at <u>11:45 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.		ADDRESS (Street, city or town, state) <u>Apexville, Ind</u> DATE SIGNED <u>18 Feb 60</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/20/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Randallstown, Ind</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jerry Byers</u> ADDRESS <u>8728 Liberty Road</u>		24a. REC'D BY REGISTRAR <u>FEB 24 '60</u> DATE	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1933

See Div. No.

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15, 1888		Baltimore, Md.	
6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF PHYSICIAN	
Clerk		Heart Disease		Home		10:30 AM		J. H. Harris	
11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS		13. SIGNATURE OF DECEASED		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF SURGEON	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF SURGEON		19. SIGNATURE OF REGISTRAR		20. SIGNATURE OF WITNESS	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	

ADVISORY BOARD OF HEALTH  
 BALTIMORE, MARYLAND  
 JANUARY 15, 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If the plate remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)  
ISM 9/59

1834

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01826

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 mths 3 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1830 Ramsey Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Freda</b> Middle <b>Susanna</b> Last <b>Kaiser</b>		4. DATE OF DEATH Month <b>2</b> Day <b>27</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-25-06</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>27</b> Days <b>27</b> Hours <b>19</b> Min. <b>60</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Wolf</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte Grossman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-09-4168</b>	
17. INFORMANT <b>S.S. Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Presenile Sclerosis (Alzheimer Disease)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause lost. (b) <b>305X</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>C.B.S. assoc. with Alzheimer disease, Pulmonary Tuberculosis, minimal, with psychotic reaction, Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>002X</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9-24-</b> <b>1960</b> to <b>2-27-</b> <b>1960</b> , that (I) (we) last saw the deceased alive on <b>2-27-</b> <b>1960</b> , and that death occurred at <b>2:15 PM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edmund Lusthaus</b>		22b. DATE <b>2-27-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3/2/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parkwood</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore City</b> <b>MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Lasson Funeral Home</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 1 '60</b>	
ADDRESS <b>17401 Baltimore</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>	



1904



*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Some words like "CITRUS" and "FRUIT" are visible.]*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Item 20 Film 255 3-10-60 ams

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01827

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto. City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN lb <u>1yr. 6mos. 21days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>3V01.4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>231 E. North Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>Margaret</u> Last <u>King</u>				4. DATE OF DEATH Month <u>February</u> Day <u>14</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>October 8, 1893</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John King</u>				14. MOTHER'S MAIDEN NAME <u>Mary Unglebowser</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>No</u>				16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Springfield Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia due to aspiration of food in</u> <u>921.7</u> DUE TO <u>larynx and bronchi.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with disease of unknown or uncertain cause, multiple sclerosis, with psychotic reaction.</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Do not know</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Do not know</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> <u>  </u> <u>  </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Springfield S. Hosp. Sykesville</u>		20f. (City or town) (County) (State) <u>Carroll Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u> EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Feb. 18, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u>	
22d. LOCATION (City, town, or county) (State) <u>Frederick, Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>M. R. Etchison &amp; Son, Frederick, Maryland</u>				24a. REC'D BY REGISTRAR <u>FEB 18 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



1  
Page 4  
hours after death.

1  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1835  
CERTIFICATE OF DEATH

01828

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>1</b> days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middletown</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		d. STREET ADDRESS <b>Route # 2 Middletown</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Elmer</b> Last <b>Kinna</b>		4. DATE OF DEATH Month <b>2</b> Day <b>14</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-9-1874</b>
9. AGE (In years last birthday) yrs. <b>86</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired independent farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David E. Kinna</b>		14. MOTHER'S MAIDEN NAME <b>Mahala Fisher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-14-8141</b>	
17. INFORMANT <b>Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mitral &amp; Aortic Valve Stenosis</b> <b>410X</b> DUE TO <b>Rheumatic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with cerebral Arteriosclerosis</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2-10</b> 19 <b>60</b> to <b>2-14</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>2-14</b> 19 <b>60</b> , and that death occurred at <b>3:55 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Agustin del Campo M.D.</b>		22b. DATE SIGNED <b>2-14-60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-17-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Luth. Cem. - Church Hill</b>		23d. LOCATION (City, town or county) (State) <b>Myersville, Md. (Rural)</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kinna</b>		25a. REC'D BY REGISTRAR <b>FEB 17 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kinna</b>			

11129

MARYLAND STATE DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS AND STATISTICS  
CERTIFICATE OF DEATH

1898

1507

Residence, C. J.

County, Md.

Age, 40

Sex, M

Color, W

Birth, 1858

Place of Birth, Md.

Married, Y

Wife, J.

Prof.,

Occup.,

Rel.,

Education, 8

Service, 0

Rank, 0

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1837 CERTIFICATE OF DEATH

01829

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>30 y 1 m 6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Agnes</b> Last <b>Krepps</b>				4. DATE OF DEATH Month <b>2</b> Day <b>12</b> Year <b>1960</b>			
5. SEX <b>Fem</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-29-68</b>	9. AGE (In years lost birthday) <b>91</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Solomon Garber</b>				14. MOTHER'S MAIDEN NAME <b>Isabell Brightwell</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>S.S. Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Thrombocytpenic purpura</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>296x</b>						INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Manic depressive reaction, depressed type.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-20-</b> 19 <b>54</b> to <b>2-12-</b> 19 <b>60</b> , that (I) (we) lost saw the deceased alive on <b>2-12-</b> 19 <b>60</b> , and that death occurred at <b>4:45 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <i>Edmund Lusthaus</i> M.D.				22b. DATE SIGNED <b>2-13-60</b>		22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>	
22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 16, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>M. R. Etchison &amp; Son, Frederick, Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 16 '60</b>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hantz</i>	

50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01830

1838

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville 28</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>505 Lee Drive</b>	
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>Elfreda</b> Last <b>KUNKELY</b>		4. DATE OF DEATH Month <b>2</b> - Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-95</b>
9. AGE (In years last birthday) <b>64</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife - OFFICE Work-RET</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rhienhold Roessler</b>		14. MOTHER'S MAIDEN NAME <b>Elfreda Amanda Vogel</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>104-22-7645</b>	
17. INFORMANT <b>Hospital records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with disturbance of metabolism, presenile psychotic reaction</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>10-20</b> , 19 <b>54</b> to <b>2-13</b> , 19 <b>60</b> that I last saw the deceased alive on <b>2-13</b> , 19 <b>60</b> , and that death occurred at <b>12-40</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2-13-60</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> <b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>15 Feb 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>NEW CATHEDRAL</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert B. Walters</b> ADDRESS <b>Pratt &amp; Stricker AS</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>			

CERTIFICATE OF DEATH

1883

Form with multiple lines for text entry, including fields for name, date, and location. The text is faint and mostly illegible due to the quality of the scan. There are several dark spots and smudges on the page, particularly on the left side.

1839

## CERTIFICATE OF DEATH

Reg. Dist. No.

01831

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MIDDLEBURG</u>				c. LENGTH OF STAY IN 1b <u>1 WEEK</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROOKFIELD-MANOR-NURSING HOME RURAL</u>				d. STREET ADDRESS <u>NEW WINDSOR</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR FRANCIS LAMBERT</u>				4. DATE OF DEATH Month Day Year <u>FEB 4 1960</u>			
5. COLOR <u>WHITE</u>		6. COLOR OR RACE <u>MALE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>13 JULY 1877</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER-OWNER-RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>FRANK LAMBERT</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET METZ</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>219-36-0914</u>			
17. INFORMANT <u>MRS. EARL HOFF</u> Address <u>NEW WINDSOR MD</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic Cardio-Vascular disease, 422.1</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>12/1/58</u> , 19____, to <u>2/4/60</u> , 19____, that I last saw the deceased alive on <u>2/4/60</u> , 19____, and that death occurred at <u>7:25 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>M. E. Robertson</u> M.D. <u>New Windsor, Md</u> <u>2/4/60</u> PHYSICIAN'S NAME (Type) <u>M. E. ROBERTSON</u> <u>NEW WINDSOR MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/7/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. [illegible]</u> ADDRESS <u>New Windsor, Md.</u>				24a. REC'D BY REGISTRAR <u>FEB 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## CERTIFICATE OF DEATH

Reg. Dist. No.

01832

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Adams</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>	c. LENGTH OF STAY IN 1b <b>3 Months</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hanover, Pa. R. D. 1</b> 75 x 3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Carroll County Home</b>		d. STREET ADDRESS <b>Hanover, Pa. R. D. 1</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Horatio</b> Middle <b>D.</b> Last <b>Leese</b>		4. DATE OF DEATH Month <b>2/11/60</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/4/1882</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.	IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>
13. FATHER'S NAME <b>Daniel Leese</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14. MOTHER'S MAIDEN NAME <b>Mary Ellen Fridinger</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Roy D. Leese, Westminster, Md. R. D. 2</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiectasis</b> 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Asthma</b> DUE TO (c) <b>Unknown causes</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Chronic</b> <b>Chronic</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>121 E. Queen St. Westminster</b>
20f. (City or town) <b>Westminster</b>		(County) (State)
21. I certify that I attended the deceased from <b>12-1-1959</b> , to <b>2-11-1960</b> , that I last saw the deceased alive on <b>2-10-1960</b> , and that death occurred at <b>4:00 A.M.</b> , from the causes and on the date stated above.		
ACTUAL SIGNATURE <b>W. C. Stone</b> M.D.		DATE SIGNED <b>2-11-1960</b>
PHYSICIAN'S NAME (Type) <b>W. C. STONE</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/13/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Bachmans Valley Cemetery</b>
22d. LOCATION (City, town, or county) <b>Nr. Westminster, Carroll Co. Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>
ADDRESS <b>Littlestown, Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>Caroline S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





Item 4 Film G255 2-8-60 et  
1841 CERTIFICATE OF DEATH

01833

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greenmount</u>		c. LENGTH OF STAY IN 1b <u>15 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WALTER-BROOKE-LEISTER</u> First Middle Last		4. DATE OF DEATH <u>Feb</u> <u>11</u> <u>1</u> , 19 <u>60</u> Month Day Year	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-23-1884</u>
9. AGE (In years last birthday) <u>75</u> -yrs.		10. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Zephaniah Leister</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Galbreith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-14-1926</u>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>330x Sub-Arachnoid Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/29/60</u> , 19 <u>  </u> , to <u>2/1/60</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>2/1/60</u> , 19 <u>  </u> , and that death occurred at <u>10:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		DATE SIGNED <u>2/2/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-5-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Leister</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edwin Stipton</u>		ADDRESS <u>Hampstead Md</u>	
24a. REC'D BY REGISTRAR <u>Feb 5 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford E. Hines</u>	

15  
X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BP

VS A15 (4)  
15M 9/58

Decedent's Name: *Walter Ernest Feister*  
Age: *10 yrs* Sex: *Male*

Place of Birth: *St. Louis, Mo.*  
Date of Birth: *12-11-1930*  
Cause of Death: *Infantile Parotiditis*  
Date of Death: *12-14-1941*

Signature of Physician: *[Signature]*  
Signature of Registrar: *[Signature]*  
Date: *12-14-1941*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
1842  
MAYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1842  
CERTIFICATE OF DEATH

01834

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>1 yr. 7 mo. 27 d</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>915 East Baltimore Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Rubin</b> Last <b>Levitz</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1960</b>											
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1876</b>		9. AGE (In years lost birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>				11. BIRTHPLACE (State or foreign country) <b>Latvia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Israel M. Rubin</b>				14. MOTHER'S MAIDEN NAME <b>Not known</b>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Springfield Hospital Records</b> Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reaction</b>												INTERVAL BETWEEN ONSET AND DEATH <b>days</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>June 6, 1958</b> to <b>February 3, 1960</b> , that (I) (we) last saw the deceased alive on <b>February 2, 1960</b> , and that death occurred at <b>7:08 A.M.</b> from the causes and on the date stated above.															
22a. SIGNATURE <b>Edmund Lusthaus</b> M.D.				22b. DATE <b>2/3/60</b>				22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2-4-60</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Herring Run</b>				23d. LOCATION (City, town, or county) <b>Balto Md</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Jacel Levine</b>				25a. REC'D BY REGISTRAR <b>FEB 4 '60</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>							

CERTIFICATE OF DEATH

1

CONFIDENTIAL

1843

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b>		2. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>BALTIMORE CITY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 mths -15 days Baltimore 1</b>		* c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3V01.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>817 N. Eutaw Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GRACE</b>		Middle <b>WELLMAN</b>		Last <b>LOVELL</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9/29/84</b>		9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Henry Lyman Lovell</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion, acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arteriosclerosis</b> DUE TO (c) <b>with psychotic reaction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>Years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with senile brain disease,</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield State Hospital</b>	
20f. (City or town) <b>Sykesville, Md.</b>		(County) <b>Carroll</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>8/25/59</b> , 19____, to <b>2/10/60</b> , 19____, that I last saw the deceased alive on <b>2/10/60</b> , 19____, and that death occurred at <b>7:45 A.M.</b> , from the causes and on the date stated above.		22a. REC'D BY REGISTRAR DATE <b>FEB 15 '60</b>		22b. REGISTRAR'S SIGNATURE <b>William S. Hines</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springfield State Hospital</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Forrest H. Russell</b>		ADDRESS <b>Pikesville, Md.</b>			

VS A15 (4)  
15M 10/57





## 1844 CERTIFICATE OF DEATH

01836

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>19Y 8M 1D</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore County - Sparks</b> d. STREET ADDRESS <b>None</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <b>Erma</b>				<b>4. DATE OF DEATH</b> Month <b>February</b> Day <b>2</b> Year <b>1960</b>											
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>January 2, 1900</b>		<b>9. AGE (In years last birthday)</b> <b>60</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		<b>IF UNDER 24 HRS.</b> Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>school teacher</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>-</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>New Jersey</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>Edwind S. Lupton</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Clara M. Wyckoff</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>Springfield Hospital records</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <b>Chronic rheumatic heart disease</b> <b>416X</b> <b>DUE TO</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b) acute systitis</b> <b>DUE TO</b> <b>(c)</b>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>years</b> <b>weeks</b>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Schizophrenic reaction, paranoid type</b>												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> <b>(IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>May 31, 1940</b> <b>to</b> <b>February 2, 1960</b> , <b>that (I) (we) lost</b> <b>saw the deceased alive on</b> <b>February 1, 1960</b> , <b>and that death occurred at</b> <b>7:10 A.M.</b> <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <b>Edmund Lusthaus</b>						<b>22b. DATE SIGNED</b> <b>2/3/60</b>									
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Edmund Lusthaus, M.D.</b>						<b>22d. ADDRESS</b> <b>Springfield Hospital, Sykesville, Md.</b>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Crementation 2/4/60</b>				<b>23b. DATE THEREOF</b> <b>2/4/60</b>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Green Mount Cemetery</b>				<b>23d. LOCATION (City, town, or county)</b> (State) <b>Baltimore, Maryland</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 9 '60</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>					

CERTIFICATE OF DEATH

1844



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1845 MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1845 CERTIFICATE OF DEATH

01837

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>22 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01-4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1731 N. Charles St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Evelyn Gertrude Litteston Matthews</b>				4. DATE OF DEATH Month Day Year <b>February 3, 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 16, 1893</b>	
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Artist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Robert Litteston</b>				14. MOTHER'S MAIDEN NAME <b>Frances Valentine</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Rheumatic heart disease with aortic stenosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>411X</b> DUE TO (c) <b>C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>January 11, 1960</b> to <b>February 3, 1960</b> , that (I) (we) last saw the deceased alive on <b>February 3, 1960</b> , and that death occurred at <b>10:20 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Ellis S. Margolin</b>				22b. DATE SIGNED <b>2/4/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Ellis S. Margolin, M.D.</b>	
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/6/60</b>		23b. DATE THEREOF <b>2/6/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge</b>		23d. LOCATION (City, town, or county) (State) <b>Balto Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Luck</b>				25a. REC'D BY REGISTRAR <b>5305 Harford</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Hume</b>	

STATEMENT OF DEATH  
IN THE DISTRICT OF COLUMBIA  
CENTRAL AID SOCIETY

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CERTIFICATE OF DEATH

01838

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>4yr. 7mo. 12days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>3605 White Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Margaret</b> Middle <b>Gertrude</b> Last <b>Miller</b>		4. DATE OF DEATH		Month <b>February</b> Day <b>10</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1974</b>		9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William S. Bartlett</b>				14. MOTHER'S MAIDEN NAME <b>Charlotte Bartlett</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute heart failure</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circulatory disturbance, 15.01 with cerebral arteriosclerosis, with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH hours  years
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 28</b> 19 <b>55</b> to <b>February 10</b> 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>February 9</b> 19 <b>60</b> , and that death occurred at <b>5:10A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Edmund Lusthaus</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>2/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Mount Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John F. Sicker, Balt. Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 15 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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Mr. J. B. ...



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>14</u> days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Katherine (Katie) Million</u>		4. DATE OF DEATH Month Day Year <u>2 6 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-26-1879</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA Naturalized</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unkn</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CBS assoc. with senile brain disease</u> <u>Metastatic carcinoma</u>		INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-23-</u> <u>1960</u> , to <u>2-6-</u> <u>1960</u> , that (I) (we) last saw the deceased alive on <u>2-6-</u> <u>1960</u> , and that death occurred at <u>11:05</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edmund Lusthaus</u> M.D.		22b. DATE <u>2-7-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u>		22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 10, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly &amp; Zeiler Inc.</u>		25a. REC'D BY REGISTRAR <u>FEB 11 '60</u>	
ADDRESS <u>1901 Eastern Ave.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

CERTIFICATE OF DEATH

1845

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DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

1848

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 3mths. 7dys.</b>		d. STREET ADDRESS <b>4113 Franklin Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>John</b>		Middle <b>William</b>		Last <b>Mock</b>		4. DATE OF DEATH Month <b>2</b> Day <b>28</b> Year <b>1960</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-2-1883</b>		9. AGE (In years last birthday) <b>76</b> yrs.		10. UNDER 1 YEAR Months Days Hours Min.		11. UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter-painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>William Mock</b>		14. MOTHER'S MAIDEN NAME <b>Mary Bertram</b>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>228-30-2596</b>		17. INFORMANT <b>Hospital records</b>		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with senile brain disease with psychotic reaction</b> <b>Large infected bed sores</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>11-21-1957 to 2-28-1960</b>		(County) <b>Montgomery Co.</b>		(State) <b>MD.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>11-21-1957</b> to <b>2-28-1960</b> , that (I) (we) last saw the deceased alive on <b>2-28-1960</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.		22a. SIGNATURE <b>Agustin del Campo</b>		22b. DATE <b>2-28-60</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo M.D.</b>		22d. ADDRESS <b>Springfield State Hospital Sykesville, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-1-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Memorial Park</b>		23d. LOCATION (City, town, or county) <b>Frederick, Md.</b>		23e. REC'D BY REGISTRAR <b>DATE MAR 1 '60</b>		23f. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>					

112910

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UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF VETERINARY MEDICINE  
DIVISION OF ANIMAL INDUSTRY  
WASHINGTON, D. C. 20501  
OFFICE OF THE VETERINARY MEDICAL OFFICER  
WASHINGTON, D. C. 20501

1848

TO THE VETERINARY MEDICAL OFFICER  
WASHINGTON, D. C. 20501  
FROM THE VETERINARY MEDICAL OFFICER  
WASHINGTON, D. C. 20501  
SUBJECT: [illegible]

[illegible text]

[illegible text]

[illegible text]

[illegible text]

CHIEF, DIVISION OF ANIMAL INDUSTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1849

01841

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>				c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Woodbine</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HARRY</b> First <b>A.</b> Middle <b>MOORE</b> Last				4. DATE OF DEATH <b>February</b> Month <b>27,</b> Day <b>1960</b> Year			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 12, 1890</b>	
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer (Retired)</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming (owner)</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Harry L. Moore</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Benard</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <b>213-36-8172</b>		17. INFORMANT <b>Mary E. Moore, Woodbine, Maryland</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest, Coronary Thrombosis,</b> <b>433.0</b> DUE TO <b>Complete heart block, arteriosclerosis -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>27 Feb 60</b> (c) <b>1956 to</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1956</b> to <b>27 Feb. 1960</b> , that (I) (we) last saw the deceased alive on <b>27 Feb. 1960</b> , and that death occurred at <b>12:30 P.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Howard E. Hall</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE <b>27 Feb 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Howard E. Hall</b>				22d. ADDRESS <b>Spencerville, Md 27 Feb 60</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>March 1, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mt. Airy, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>G. M. WALTZ, Winfield, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur E. Evans</b>	

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1948

City of

State of

County of

Residence

Age

Occupation

Married

Single

Dec. 11, 1948

Dec. 11, 1948

Dec. 11, 1948

Dec. 11, 1948

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Dec. 11, 1948



## CERTIFICATE OF DEATH

Reg. Dist. No.

01842

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>585 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Selbyville</b>		d. STREET ADDRESS <b>Route #2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Isaac</b> Middle <b>Isaac</b> Last <b>Moore</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-26-1889</b>
9. AGE (In years last birthday) <b>70 yrs.</b>		IF UNDER 1 YEAR Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>	IF UNDER 24 HRS. Months <b>70</b> Days <b>70</b> Hours <b>70</b> Min. <b>70</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Snow Hill, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Isaac Showell</b>	
14. MOTHER'S MAIDEN NAME <b>Bell West</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>221-24-9569</b>		INFORMANT Address <b>Katie Stevenson - Daughter</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO <b>Far advanced bilateral cavitory pulmonary TB</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Pulmonary emphysema</b> (c) <b>Pulmonary emphysema</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 15</b> , 19 <b>58</b> , to <b>February 20</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>February 20</b> , 19 <b>60</b> , and that death occurred at <b>5:15 A.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. M. Maculans M. D.</b>		ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D.</b>		DATE SIGNED <b>2-20-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2-25-1960</b>		22b. DATE THEREOF <b>2-25-1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LONG</b>		22d. LOCATION (City, town, or county) (State) <b>SELBYVILLE DEL.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert Whitham Elwell City Md</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
ADDRESS <b>Elwell City Md</b>		DATE <b>FEB 24 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CENTRAL OF TEXAS

1953

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1801 CERTIFICATE OF DEATH

01843

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>				c. LENGTH OF STAY IN 1b <u>30 yrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Davis Apartments</u>				e. STREET ADDRESS <u>Cor. Main &amp; John Sts.</u>			
3. NAME OF DECEASED (Type or print) <u>JOHN FRANKLIN MOORE</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>16</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 14, 1894</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Black &amp; Black (Guard)</u>		11. BIRTHPLACE (State or foreign country) <u>Berwick, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Moore</u>				14. MOTHER'S MAIDEN NAME <u>Anna Seely</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-24 7958</u>		17. INFORMANT <u>Mrs. Ruthanna W. Moore</u> Address <u>Westminster Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>196.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of mandible (rt)</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 MOS.</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>July 4, 1948</u> , to <u>February 13, 1960</u> , that I last saw the deceased alive on <u>Feb- 16, 1960</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius Chepko</u>				ADDRESS (Street, city or town, state) <u>854 W. Green St Westminster Md</u>			
PHYSICIAN'S NAME (Type) <u>Julius Chepko</u>				DATE SIGNED <u>3/17/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb- 19-60</u>		<u>Meadow Brook</u>		<u>Rural Westminster Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr.</u> ADDRESS <u>Westminster Md</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

CERTIFICATE OF DEATH

1901

NAME OF DECEASED <i>John William Smith</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>Jan 15 1901</i>	
PLACE OF DEATH <i>Home</i>		CITY <i>Baltimore</i>		COUNTY <i>Harford</i>		STATE <i>Md.</i>		COUNTRY <i>U.S.A.</i>	
OCCUPATION <i>Farmer</i>		EDUCATION <i>Common School</i>		RELIGION <i>Methodist</i>		MARRIAGE <i>Married</i>		SINGLE	
CAUSE OF DEATH <i>Heart Disease</i>		DISEASE <i>Myocarditis</i>		SYMPTOMS <i>Shortness of breath, swelling of feet</i>		TREATMENT <i>Medicine</i>		DIAGNOSIS <i>By Dr. J. H. Smith</i>	
SIGNATURE OF PHYSICIAN <i>J. H. Smith</i>		SIGNATURE OF DECEASED <i>John W. Smith</i>		SIGNATURE OF WITNESSES <i>Wm. J. Brown, Mary A. Green</i>		SIGNATURE OF CLERK <i>John D. White</i>		SIGNATURE OF REGISTRAR <i>John E. Black</i>	
DATE OF SIGNATURE <i>Jan 15 1901</i>		DATE OF SIGNATURE <i>Jan 15 1901</i>		DATE OF SIGNATURE <i>Jan 15 1901</i>		DATE OF SIGNATURE <i>Jan 15 1901</i>		DATE OF SIGNATURE <i>Jan 15 1901</i>	

This certificate is to be filled out by the physician or other person authorized by the State Department of Health.

IN WITNESS WHEREOF

1851

## CERTIFICATE OF DEATH

01844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Westminster</b>				c. LENGTH OF STAY IN 1b <b>30 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R-1 (Silver Run)</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harry</b> Middle <b>Leroy</b> Last <b>Myers</b>				4. DATE OF DEATH Month <b>2/5/60</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12/5/1883</b>	
9. AGE (In years last birthday) yrs. <b>76</b>		IF UNDER 1 YEAR Months <b>76</b> Days <b>76</b> Hours <b>76</b> Min. <b>76</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Peter Myers</b>				14. MOTHER'S MAIDEN NAME <b>Emaline Humbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-18-1783</b>		17. INFORMANT <b>Mrs. Harry L. Myers, Westminster, Md. R-1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio-Vascular Disease</b> DUE TO (c) <b>10 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 2, 1960</b> to <b>Feb 5, 1960</b> , that I last saw the deceased alive on <b>Feb 5, 1960</b> , and that death occurred at <b>7:20P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>L. L. Potter M.D.</b>				ADDRESS (Street, city or town, state) <b>12 W. King St. Littlestown, Pa</b>			
PHYSICIAN'S NAME (Type) <b>L. L. POTTER M.D.</b>				DATE SIGNED <b>2-6-60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/8/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Littlestown, Adams Co., Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>				ADDRESS <b>Littlestown, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 9 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







1852

CERTIFICATE OF DEATH

01845

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b> c. LENGTH OF STAY IN 1b <b>3 mo.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weitzel Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy X</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MERTIE L. PENN</b> First Middle Last		4. DATE OF DEATH <b>February 24, 1960</b> Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 5, 1880</b> 9. AGE (In years last birthday) <b>79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Gosnell</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Duvall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Ferris R. Penn, Mt. Airy, Maryland</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Cervix Uteri</b> 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>More than 2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept 1959</b> to <b>Feb 1960</b> , that I last saw the deceased alive on <b>Jan 25, 1960</b> , and that death occurred at <b>4:45 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W.B. Culwell</b>		ADDRESS (Street, city or town, state) <b>900 So. Main St.</b> DATE SIGNED <b>2/24/60</b>	
PHYSICIAN'S NAME (Type) <b>W. B. Culwell</b>		M.D. <b>900 So. Main St., Mt. Airy, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-26-1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Winfield Church of God</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. WALTZ., Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 29 '60</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Evans</b>	

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AP

CERTIFICATE OF DEATH

1938

Form with multiple lines for text entry, including fields for name, date, and cause of death. The text is faint and mostly illegible.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01846

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <span style="font-size: 1.5em;">1853</span> <span style="margin-left: 100px;">Carroll</span> <span style="margin-left: 100px;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <span style="margin-left: 20px;">Maryland</span> <span style="margin-left: 20px;">b. COUNTY</span> <span style="margin-left: 20px;">Baltimore</span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Sykesville</span>		c. LENGTH OF STAY IN 1b <span style="font-size: 1.2em;">30yrs. 11mos. 6days</span>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <span style="font-size: 1.2em;">Cockeysville</span> <span style="float: right;">03X-2</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <span style="font-size: 1.2em;">Springfield State Hospital</span>				d. STREET ADDRESS <span style="font-size: 1.2em;">None</span>			
<b>3. NAME OF DECEASED</b> (Type or print) First <span style="margin-left: 20px;">Catherine</span> Middle <span style="margin-left: 20px;">B.</span> Last <span style="margin-left: 20px;">Remmells</span>				<b>4. DATE OF DEATH</b> Month <span style="margin-left: 20px;">February</span> Day <span style="margin-left: 20px;">3,</span> Year <span style="margin-left: 20px;">19 60</span>			
<b>5. SEX</b> <span style="font-size: 1.2em;">Female</span>		<b>6. COLOR OR RACE</b> <span style="font-size: 1.2em;">White</span>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">X1902 2-26-1901</span>		<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">X58 yrs.</span>		<b>10. IF UNDER 1 YEAR</b> Months <span style="margin-left: 20px;"></span> Days <span style="margin-left: 20px;"></span> Hours <span style="margin-left: 20px;"></span> Min. <span style="margin-left: 20px;"></span>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housework</span>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">-</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>			
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">U.S.A.</span>				<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Daniel Remmells</span>			
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Emma Thompson</span>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <span style="margin-left: 20px;">No</span> <span style="margin-left: 20px;">(If yes, give war or dates of service)</span> <span style="margin-left: 20px;">-</span>			
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">-</span>		<b>17. INFORMANT</b> <span style="margin-left: 20px;">Address</span> <span style="font-size: 1.2em;">Springfield Hospital Records</span>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p><b>PART I. DEATH WAS CAUSED BY:</b></p> <p><b>IMMEDIATE CAUSE (a)</b> <span style="font-size: 1.2em;">Pulmonary edema and bronchopneumonia</span></p> <p><b>260x</b> <span style="margin-left: 20px;">DUE TO</span> <span style="margin-left: 20px;">(b) Hyperglycemic coma</span></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p><b>DUE TO</b> <span style="margin-left: 20px;">(c) Thrombophlebitis of the right ileac vein</span></p> </div> <div style="width: 15%; text-align: center;"> <p><b>INTERVAL BETWEEN ONSET AND DEATH</b></p> <p><span style="font-size: 1.2em;">Days</span></p> <p><span style="font-size: 1.2em;">Days</span></p> <p><span style="font-size: 1.2em;">Days</span></p> </div> </div> <p><b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b></p> <p><span style="font-size: 1.2em;">Epilepsy with mental deficiency. Fracture, neck of right femur.</span></p>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <span style="font-size: 1.2em;">Patient was found lying on floor.</span>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <span style="font-size: 1.2em;">9:30 a.m. 1/26/ 1960</span>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">Hospital</span>			
<b>20f. (City or town)</b> <span style="font-size: 1.2em;">Sykesville</span>		<b>(County)</b> <span style="font-size: 1.2em;">Carroll</span>		<b>(State)</b> <span style="font-size: 1.2em;">Md.</span>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input checked="" type="checkbox"/> <b>Inspection</b> <input checked="" type="checkbox"/> <b>Inquiry</b> <input checked="" type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
<b>ACTUAL SIGNATURE</b> <span style="font-size: 1.5em;">James T. Marsh</span> <span style="margin-left: 20px;">M.D.</span>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>			
<b>EXAMINER'S NAME (Type)</b> <span style="font-size: 1.2em;">James T. Marsh, M.D.</span>				<b>DATE SIGNED</b> <span style="font-size: 1.2em;">2/4/60</span>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <span style="font-size: 1.2em;">Burial</span>		<b>22b. DATE THEREOF</b> <span style="font-size: 1.2em;">2-6-1960</span>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Poplar Grove Cemetery</span>			
<b>22d. LOCATION (City, town, or county)</b> <span style="font-size: 1.2em;">Cockeysville</span>		<b>(State)</b> <span style="font-size: 1.2em;">Md.</span>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <span style="font-size: 1.2em;">Brooks Funeral Service</span> <span style="margin-left: 20px;">Towson 4, Md.</span>				<b>24a. REC'D BY REGISTRAR</b> <span style="font-size: 1.2em;">FEB 8 '60</span>			
<b>24b. REGISTRAR'S SIGNATURE</b> <span style="font-size: 1.2em;">Arthur S. Kraus</span>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
Baltimore, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital at the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01847

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Carroll</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Hycksville</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Hycksville</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>ELLEN PEACE REYNOLDS</i>		4. DATE OF DEATH <i>Feb. 17 1960</i>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov. 16, 1883</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John T. Alexander</i>		14. MOTHER'S MAIDEN NAME <i>Mathie Belt</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-12-2726</i>	
17. INFORMANT <i>M. Ellen H. Reynolds-Hycksville, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac failure, Coronary Arteriosclerosis, 481X</i>			
DUE TO (b) <i>Arteriosclerosis generalized, Hypertension</i>			
DUE TO (c) <i>Influenza</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1956</i> 19 to <i>17 Feb</i> 19 <i>60</i> , that (I) (we) last saw the deceased alive on <i>17 Feb 19 60</i> , and that death occurred at <i>11:00</i> M., from the causes and on the date stated above.			
22a. SIGNATURE <i>Howard E. Hall</i>		22b. DATE SIGNED <i>2-19-60</i>	
22c. PHYSICIAN'S NAME (Type) <i>HOWARD E. HALL</i>		22d. ADDRESS <i>Hycksville, Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-20-60</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Woods Chapel</i>		23d. LOCATION (City, town, or county) (State) <i>Hycksville, Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur H. Hight</i>		25a. REC'D BY REGISTRAR <i>FEB 23 1960</i>	
ADDRESS <i>Hycksville, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Hight</i>	

11813

DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH

1884

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DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
STATE OF NEW YORK  
CERTIFICATE OF DEATH



**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

01848

1855

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		d. STREET ADDRESS 		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
<b>3. NAME OF DECEASED</b> (Type or print) <u>ROSIE</u> First <u>LEE</u> Middle <u>RHEA</u> Last <u>BOTTOM</u>				<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>9</u> Year <u>1960</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 13, 1882</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handwork</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Andrew Dorsey</u>				14. MOTHER'S MAIDEN NAME <u>Euganna Dorsey</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mr. Edward Dorsey - Sykesville, Md.</u>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>446X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Per. Heart failure</u> DUE TO (c) <u>Hypertension, Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>months</u> <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Feb. 7, 1960</u> to <u>Feb. 9, 1960</u> that (I) (we) last saw the deceased alive on <u>Feb. 8, 1960</u> , and that death occurred at <u>12:20 P.M.</u> from the causes and on the date stated above.								
22a. SIGNATURE <u>Sani O. Kutman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/10/60</u>		
22c. PHYSICIAN'S NAME (Type) <u>SANI KUTMAN</u>				22d. ADDRESS <u>Sykesville, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-11-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bushy Park</u>		23d. LOCATION (City, town, or county) (State) <u>Cookeville, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight - Sykesville, Md.</u> ADDRESS				25a. REC'D BY REGISTRAR <u>FEB 12 '60</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Arthur H. Haight</u>		

11-1-12

STATE OF MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CITY OF BOSTON

1893

MASSACHUSETTS  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CITY OF BOSTON

11-1-12

11-1-12

11-1-12

11-1-12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

1856

CERTIFICATE OF DEATH

01849

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN lb <u>15 yrs 4m 2 days</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>City</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore, Md.</u> <u>3401-4</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>2140 Boyd Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>E</u> Last <u>Riley</u>		4. DATE OF DEATH Month <u>2</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>8-19-01</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>Harman A. Riley</u>		14. MOTHER'S MAIDEN NAME <u>Katherine Moran</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unkn</u>		17. INFORMANT <u>Hospital Records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic hypertensive heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis with chronic alcoholism</u>					INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-20-1954</u> to <u>2-7-1960</u> that (I) (we) last saw the deceased alive on <u>2-7-1960</u> , and that death occurred at <u>2:15 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Edmund Lusthaus</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-7-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus M.D.</u>		22d. ADDRESS <u>Springfield State Hospital, Sykesville, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/10/1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cem</u>	
		23d. LOCATION (City, town, or county) <u>Ritchie Co. Md.</u>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thomas J. Kenney Inc - Boothellins St</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>Feb 9 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

UNITED STATES DEPARTMENT OF HEALTH  
BUREAU OF PUBLIC HEALTH  
DIVISION OF LABORATORY INVESTIGATION  
CERTIFICATE OF DEATH

1955

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7

CHIEF EXAMINER

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01850

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>CARROLL</u> <span style="float: right;">1857</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> c. LENGTH OF STAY IN 1b <u>YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>MAIN ST</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR</u> d. STREET ADDRESS <u>MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>PRESTON BAILE ROOP</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>FEB. 9 1960</u> Month Day Year				
<b>5. SEX</b> <u>MALE</u>		<b>6. COLOR OR RACE</b> <u>WHITE</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>20 FEB. 1886</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>9. AGE</b> (In years last birthday) <u>73</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>BROKER-REAL ESTATE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>MARYLAND</u>			
<b>11. BIRTHPLACE</b> (State or foreign country) <u>U.S.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>JOHN H. ROOP</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNIE DEVILBISS</u>		<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>219-14-9130</u>			
<b>17. INFORMANT</b> <u>MRS. NETTIE B. ROOP, NEW WINDSOR MD.</u> Address		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b> _____		<b>(County)</b> _____		<b>(State)</b> _____			
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> , <b>Inspection</b> <input checked="" type="checkbox"/> , <b>Inquiry</b> <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>James T. Marsh</u> <b>EXAMINER'S NAME (Type)</b> <u>JAMES T. MARSH</u>		<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>		<b>DATE SIGNED</b> <u>2/9/60</u>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>12 FEB 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>PIPE CREEK CEM</u>			
<b>22d. LOCATION (City, town, or county)</b> <u>CARROLL COUNTY MD.</u>		<b>(State)</b> _____		<b>24a. REC'D BY REGISTRAR</b> <u>FEB 12 '60</u>			
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Arthur S. Thomas</u> <b>ADDRESS</b> <u>NEW WINDSOR MD</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Thomas</u>		<b>DATE</b> _____			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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1858  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1858  
CERTIFICATE OF DEATH

01851

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN 1b <u>6mos. 14 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LeGore</u> <u>10X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Silas</u> Middle <u>Clayton</u> Last <u>Schildt</u>				4. DATE OF DEATH Month <u>February</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>May 31, 1878</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lime Plant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>xxxxxxx David W. Schildt</u>				14. MOTHER'S MAIDEN NAME <u>xxxxxxx Elizabeth Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-2112</u>		17. INFORMANT <u>Springfield Hospital Records</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gangrene of right foot</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Peripheral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction, plus alcoholism</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 24, 1959</u> to <u>February 8, 1960</u> , that (I) (we) last saw the deceased alive on <u>February 8 1960</u> , and that death occurred at <u>8 PM</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Agustin del Campo</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/9/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Agustin del Campo, M.D.</u>				22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>			
23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-11-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Church of Brethern Com. Rocky Ridge, Fred. Co.</u>		23d. LOCATION (City, town, or county) (State) <u>  </u> <u>  </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Raymond E. Egan</u>				ADDRESS <u>Thurmont, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 12 '60</u>	
						25b. REGISTRAR'S SIGNATURE <u>  </u>	

CERTIFICATE OF DEATH

1948

Time of death

xxxxxx Elizabeth Jones

xxxxxx David M. Goffin

211-10-2110

Thompson, Md.

2-11-50

Church of Brethren Con. Book 111, Page 10.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital and the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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1859  
MARYLAND STATE BOARD OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01852

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>27yrs. 26days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Conrad</u> Middle <u>Drew</u> Last <u>Shafer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>7</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 27, 1902</u>
9. AGE (In years lost birthday) yrs. <u>57</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>16</u> Hours <u>8</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Franklin Shafer</u>		14. MOTHER'S MAIDEN NAME <u>Mattie B. Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Pulmonary edema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Day</u> <u>Years</u> <u>Hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dementia Praecox</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>October 20, 1951</u> to <u>Feb. 7, 1960</u> , that (I) (we) last saw the deceased alive on <u>2/3</u> 19 <u>60</u> , and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Edmund Lusthaus</u> M.D.		22b. DATE SIGNED <u>2/8/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edmund Lusthaus, M.D.</u>		22d. ADDRESS <u>Springfield Hospital, Sykesville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-11-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Frederick-Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Daileys Funeral Home</u>		25a. REC'D BY REGISTRAR <u>FEB 15 '60</u>	
ADDRESS <u>Frederick-Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Carroll S. Hume</u>	

100-100000

CERTIFICATE OF DEATH

1822

1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of death: [illegible]  
5. Place of death: [illegible]  
6. Cause of death: [illegible]  
7. Signature of physician: [illegible]  
8. Signature of registrar: [illegible]  
9. Date of registration: [illegible]



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester #</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester, R.D. 1</u>	
c. LENGTH OF STAY IN 1b <u>Life</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Carroll</u> Middle <u>David</u> Last <u>Shaffer</u>		4. DATE OF DEATH Month <u>February</u> Day <u>11</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 27, 1896</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>huckster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John W. Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Carrie C. Shaffer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>219-12-0888</u>	
17. INFORMANT <u>Carrie C. Shaffer</u>		Address <u>Manchester, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shot Gun Blast of Head</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>  </u> (c) <u>  </u> DUE TO cause lost. (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Anxiety-Depression</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>Inst.</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>12 Gauge shot gun in mouth. Pulled trigger.</u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour</u> <u>2:13 PM</u> <u>Feb. 11, 1960</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Manchester</u> <u>Carroll</u> <u>Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M.C. Porterfield</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M.C. Porterfield, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>2/11/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/13/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Manchester, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Becker</u>		24. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

COUNTY OF <u>NEW YORK</u> CITY OF <u>NEW YORK</u>		DECEASED <u>JOHN J. ROSS</u>	
PLACE OF DEATH <u>100 WEST 100TH STREET, NEW YORK 24, N.Y.</u>		DATE OF DEATH <u>APRIL 10, 1968</u>	
TIME OF DEATH <u>11:00 P.M.</u>		SEX <input checked="" type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
RACE <input checked="" type="checkbox"/> WHITE <input type="checkbox"/> NEGRO <input type="checkbox"/> OTHER		AGE <u>45</u>	
OCCUPATION <u>MANUFACTURING</u>		MARITAL STATUS <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	
PREVIOUS ILLNESS <u>NO</u>		CAUSE OF DEATH <u>HEART DISEASE</u>	
MANNER OF DEATH <input checked="" type="checkbox"/> NATURAL <input type="checkbox"/> ACCIDENTAL <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> UNDETERMINED		SIGNATURE OF MEDICAL EXAMINER <u>[Signature]</u>	
SIGNATURE OF WITNESS <u>[Signature]</u>		SIGNATURE OF DECEASED <u>[Signature]</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01854

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster RURAL</b> c. LENGTH OF STAY IN lb <b>2 yrs.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route # 140</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster RURAL</b> d. STREET ADDRESS <b>R.D.#2</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EDGAR (EDWARD) SUTHARD</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1916</b>
9. AGE (In years last birthday) <b>43</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Nursery</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elisah Suthard</b>		14. MOTHER'S MAIDEN NAME <b>Estell Heflin</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-128352</b>	
17. INFORMANT <b>Laura Smith Suthard, Westminster, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>816x FRACTURE of SKULL</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>—</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile accident - collision</b>	
20c. TIME OF INJURY Month, Day, Year <b>6:40 a.m. 2-8 1960</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 140 - Westminster</b>		20f. (City or town) <b>Carroll</b> (County) <b>Md</b> (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>James T. Marshall</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2-8-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 11, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>York</b> (State) <b>Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.M. Waltz, Winfield, Maryland</b>		24a. REC'D BY REGISTRAR <b>FEB 11 '60</b> DATE	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

MEDICAL CERTIFICATION

06

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1901

*John*

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JOHN		35		M		W		1866		BALTIMORE, MD	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		SINGLE		MARRIED	
BALTIMORE, MD		LABORER		HIGH SCHOOL		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
JAN 10 1901		BALTIMORE, MD		HEART DISEASE		NATURAL		HEART DISEASE		HEART DISEASE	
TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
10:00 AM		BALTIMORE, MD		HEART DISEASE		NATURAL		HEART DISEASE		HEART DISEASE	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
JAN 10 1901		BALTIMORE, MD		HEART DISEASE		NATURAL		HEART DISEASE		HEART DISEASE	
TIME OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
10:00 AM		BALTIMORE, MD		HEART DISEASE		NATURAL		HEART DISEASE		HEART DISEASE	
DATE OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
JAN 10 1901		BALTIMORE, MD		HEART DISEASE		NATURAL		HEART DISEASE		HEART DISEASE	
TIME OF EXAMINATION		PLACE OF EXAMINATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		SYMPTOMS	
10:00 AM		BALTIMORE, MD		HEART DISEASE		NATURAL		HEART DISEASE		HEART DISEASE	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

01855

1862

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN lb <b>2 Months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Grand View Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glyndon</b> d. STREET ADDRESS <b>119 Central Ave.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Taylor</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3, 1873</b>
9. AGE (In years at birthday) <b>86</b> yrs.		10. UNDER 1 YEAR Months <b>11</b> Days <b>19</b> Hours <b>19</b> Min.	11. UNDER 24 HRS. Months <b>11</b> Days <b>19</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Geo. Kent Bellows</b>		Address <b>119 Central Ave. Glyndon, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>myocarditis - Decompensating</b> 443X DUE TO (b) <b>Hypertension &amp; arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (c), stating the <u>under</u> lying cause lost. DUE TO (c) <b>years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>2 yrs</b> INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-1-1930</b> to <b>2-7-60</b> , that I last saw the deceased alive on <b>2-6-60</b> , and that death occurred at <b>6 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James G. Spaffell</b>		DATE SIGNED <b>Feb 8 1960</b>	
PHYSICIAN'S NAME (Type) <b>James G. Spaffell</b>		ADDRESS (Street, city or town, state) <b>Reisterstown, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 9, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 10 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

DEPARTMENT OF HEALTH - BOSTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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1863

01856

1863

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3yrs.9mos.24days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Port Deposit</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				d. STREET ADDRESS <b>None</b>			
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Taylor</b> Last <b>Taylor</b>				4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. B. DATE OF BIRTH <b>1931</b>	
9. AGE (In years lost birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months <b>28</b> Days <b>07</b> Hours <b>X</b> Min. <b>2</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Ira H. Taylor</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary tuberculosis, far advanced, active</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>002X</b> DUE TO (c) <b>002X</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with birth trauma with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 25, 1956</b> to <b>February 19, 1960</b> , that (I) (we) last saw the deceased alive on <b>February 18, 1960</b> , and that death occurred at <b>1:40AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				22b. DATE <b>2/19/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>	
22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>2-22-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Charmant Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Howell</b>				25a. REC'D BY REGISTRAR <b>Pibes - 8</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

01850

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
CERTIFICATE OF DEATH  
1883

State of Massachusetts,  
County of \_\_\_\_\_  
City of \_\_\_\_\_  
I, \_\_\_\_\_  
do hereby certify that \_\_\_\_\_  
born \_\_\_\_\_  
died \_\_\_\_\_  
at \_\_\_\_\_  
on the \_\_\_\_\_ day of \_\_\_\_\_  
1883.  
Attest:  
\_\_\_\_\_  
Registrar of Vital Records



MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01857

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Airy</b>			c. LENGTH OF STAY IN lb <b>6 yrs.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>home - Mt. Airy</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>JAMES M. THOMAS</b>			4. DATE OF DEATH <b>February 21 1960</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <b>March 17, 1938</b>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S.A.F.</b>		9. AGE (In years last birthday) <b>21</b> yrs.		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S.A.F.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Co. Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>George G. Thomas</b>		
14. MOTHER'S MAIDEN NAME <b>Justa Witherspoon</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		
16. SOCIAL SECURITY NO. <b>6-57 to 60 214-36-0389</b>			17. INFORMANT <b>George C. Thomas, Mt. Airy, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carbon monoxide poisoning</b> 891.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Asphyxiated while working on car in closed garage</b>			
20c. TIME OF INJURY Month, Day, Year <b>10:45 xx 2/21/1960</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Garage</b>	
20f. (City or town) <b>Mt. Airy, Md.</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Russell S. Fisher</b>		M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 24-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pine Grove Cemetery</b>	
22d. LOCATION (City, town, or country) <b>Mt. Airy, Carroll Co. Md.</b>		22e. (State)			
23. FUNERAL DIRECTOR <b>C. M. WALTZ, WINFIELD, MARYLAND</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>FEB 25 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>		DATE			

2/22/60

2

1970s

1992

1994

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
1864  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

01858

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3mos. 2days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Earroll</b> Last <b>Compton</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 9, 1887</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurses Aide</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Compton</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Carroll</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>217-20-6772</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <b>-</b> DUE TO <b>-</b> (c) <b>-</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with cerebral arteriosclerosis with psychotic reaction.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>-</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 21, 1959</b> to <b>February 23, 1960</b> , that (I) (we) last saw the deceased alive on <b>Feb. 23, 1960</b> , and that death occurred at <b>2:55 AM</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edmund Lusthaus</b> M.D.		22b. DATE SIGNED <b>2/23/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-25-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		23d. LOCATION (City, town, or county) (State) <b>BALTO, CO.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Chmura</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 24 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiana</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
1865  
CERTIFICATE OF DEATH

01859

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>30yr.6mo.8days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>3103 Mareco Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>James T. Tuohy</b>			4. DATE OF DEATH <b>February 9 19 60</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 6, 1907</b>	
9. AGE (In years lost birthday) <b>52</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Odd jobs</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland, Baltimore</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Tuohy</b>		14. MOTHER'S MAIDEN NAME <b>Annie Sullivan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Far advanced bilateral pulmonary tuberculosis</b> <b>002 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with Constitutional Psychopathic Personality</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>July 31 19 29</b> to <b>February 8 19 60</b> , that (I) (we) last saw the deceased alive on <b>February 8 19 60</b> , and that death occurred at <b>4:15 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Agustin del Campo</b>				22b. DATE SIGNED <b>2/9/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo</b>				22d. ADDRESS <b>Springfield Hospital, Sykesville, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2/12/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Schimunek</b> ADDRESS <b>Funeral Home 3331 Brehms Lane</b>				25a. REC'D BY REGISTRAR <b>FEB 11 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





1

1866

CERTIFICATE OF DEATH

01860

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>6mo. 17days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>3V01.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>4315 Harford Road</b>			
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Franklin</b> Last <b>Wagner</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1883</b>		9. AGE (In years last birthday) <b>76</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>	IF UNDER 24 HRS. Hours <b>11</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Employee B.&amp;O.R.R.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Herman Wagner</b>				14. MOTHER'S MAIDEN NAME <b>Amelia</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>Bronchopneumonia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b> <b>days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction</b>							19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>July 24, 1959</b> to <b>February 11, 1960</b> , that (I) (we) last saw the deceased alive on <b>February 10, 1960</b> and that death occurred at <b>10:56 A.M.</b> the causes and on the date stated above.			
22a. SIGNATURE <b>Agustini del Campo</b> M.D.				22b. DATE SIGNED <b>2/11/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>	
22d. ADDRESS <b>Springfield State Hospital, Sykesville, Md.</b>				23a. REC'D BY REGISTRAR <b>FEB 18 '60</b>			
23b. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23c. DATE THEREOF <b>2-15-60</b>		23d. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		23e. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck</b> ADDRESS <b>5305 Harford Rd</b>				25a. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

01840

CERTIFICATE OF ORIGIN

1844

THIS CERTIFICATE OF ORIGIN is hereby issued to the undersigned, who is the owner of the property described in the foregoing schedule, and who is entitled to the same under the provisions of the Act of Congress, approved March 3, 1878, entitled "An Act to provide for the relief of the people of the United States in respect to the duties on certain articles of foreign origin."

The property described in the foregoing schedule is hereby certified to be the property of the undersigned, and to be entitled to the same under the provisions of the Act of Congress, approved March 3, 1878, entitled "An Act to provide for the relief of the people of the United States in respect to the duties on certain articles of foreign origin."

The undersigned hereby certifies that the property described in the foregoing schedule is the property of the undersigned, and to be entitled to the same under the provisions of the Act of Congress, approved March 3, 1878, entitled "An Act to provide for the relief of the people of the United States in respect to the duties on certain articles of foreign origin."

Witness my hand and seal this 1st day of January, 1844.

JOHN J. HARRIS

Secretary of the Treasury

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1867

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

01861

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>230 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>Route 1, Box 39</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Minnie Grace Webb</b>		4. DATE OF DEATH Month Day Year <b>February 8 19 60</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-22-1890 1899</b>
9. AGE (In years lost birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Federalburg, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Daniel Hubbard</b>		14. MOTHER'S MAIDEN NAME <b>Eliza <del>Webb</del> Murray</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-01-9432</b>	
17. INFORMANT <b>Grace Webb - Same as patient</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> 002x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Far adv. bilat. pulmonary tbc. w cavity right</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 23</b> , 19 <b>59</b> , to <b>February 8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>February 8</b> , 19 <b>60</b> , and that death occurred at <b>8:35A</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edgars M. Maculans M. D.</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Henryton, Maryland 2-8-60</b>	
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D.</b>		<b>Henryton State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 13, 1960</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Johns Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Preston, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton, Jr.</b>		ADDRESS <b>Federalburg, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 15 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

1987

State of California

County of

City of

Married

Deceased

Age

Place of Birth

Date of Death

Time of Death

Place of Death

Sex

Color

Height

Weight

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

Signature of

MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1868

01862

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weitzel Nursing Home</b>				d. STREET ADDRESS <b>Clarksville</b>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM H. WIDERMAN</b> First Middle Last <b>Widerman</b>				4. DATE OF DEATH <b>Feb. 18, 1960</b> Month Day Year <b>19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 29, 1876</b>	9. AGE (In years lost birthday) <b>83</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore, Md</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>None</b>				13. FATHER'S NAME <b>Levi Widerman</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Mrs. Frank Cameron, Ellicott City, Md</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure, Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized, bronchial pneumonia</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1957</b> <b>18 Feb 60</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1959</b> 19 to <b>18 Feb</b> 19 <b>60</b> , that (I) (we) last saw the deceased alive on <b>18 Feb</b> 19 <b>60</b> and that death occurred at <b>M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Howard E. Hall</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>18 Feb 60</b>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS <b>Apartment, Mt</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-20-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>		23d. LOCATION (City, town, or county) (State) <b>Randallstown, Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>				25a. REC'D BY REGISTRAR <b>FEB 23 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

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AP

CERTIFICATE OF DEATH

1882

Lowland

Region

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1882

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Illinois

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1863

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6 yrs. 26 dys.</b> <b>Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>813 Gephart Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>-</b> Last <b>Williams</b>		4. DATE OF DEATH Month <b>2</b> Day <b>15</b> Year <b>1960</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/21/93</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Rev. Joshua B. Whaling</b>		14. MOTHER'S MAIDEN NAME <b>Alice V. Beardsley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>Hospital records, Springfield State Hosp.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxia due to obstruction of both bronchi by food.</b> INTERVAL BETWEEN ONSET AND DEATH <b>305X</b> hours DUE TO (b) <b>Pulmonary congestion and edema.</b> hours DUE TO (c) <b>Pick's Disease of the brain.</b> years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Involuntional psychotic reaction.</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 18</b> , 19 <b>58</b> , to <b>Feb. 15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Feb. 15</b> , 19 <b>60</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Konstantin Weber</b> M.D.		ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b> DATE SIGNED <b>2-16-1960</b>	
PHYSICIAN'S NAME (Type) <b>Konstantin Weber, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/18/60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	22d. LOCATION (City, town, or county) (State) <b>Beallsville Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Constance C. Hilton</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 19 '60</b>	
ADDRESS <b>Barnesville Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1862

DECEASED

AGE

CAUSE

DATE

PLACE

TIME

SEX

COLOUR

NO. OF

NAME OF

RESIDENCE

AGE

SEX

COLOUR

RESIDENCE

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1870 CERTIFICATE OF DEATH

Reg. Dist. No. 01864

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM - A - ZEPP</u>		4. DATE OF DEATH <u>Feb</u> <u>28</u> <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 11 - 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Road</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Zepp</u>		14. MOTHER'S MAIDEN NAME <u>Sarah J Kerchner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-36-8304</u>	
17. INFORMANT <u>Mr Edw ZEPP - Manchester, Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>14 mo</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/24</u> , 19 <u>60</u> , to <u>2/28</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2/28/60</u> , 19 <u>60</u> , and that death occurred at <u>1 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M. C. Porterfield</u>		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u>	
PHYSICIAN'S NAME (Type) <u>M. C. Porterfield</u>		DATE <u>2/29/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar 2 - 60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran</u>	22d. LOCATION (City, town, or county) (State) <u>Manchester Carroll Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Chipton</u>		24a. REC'D BY REGISTRAR <u>Mar 2 '60</u>	
ADDRESS <u>Hampstead Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1898 - CERTIFICATE OF DEATH

Dec 20 1898  
William A. - A - 2599 - 1898  
X  
A

Dec 20 1898  
A